VA-SBIRT Final Report

NOVEMBER 2021

Changing lives one screen at a time…

VA-SBIRT

Screening, Brief Intervention, and Referral to Treatment

CONTENTS

ACKNOWLDEGMENTS

Thank You

The Virginia SBIRT project team would like to acknowledge the collaborative partnership among among Virginia's Department of Behavioral Health and Developmental Services (DBHDS), A Division for Advancing Prevention and Treatment (ADAPT), the Center for Behavioral Health Integration (C4BHI), and George Mason University in designing and executing the Virginia SBIRT Project. We are especially grateful to our healthcare partners for their dedicated approach to integrating SBIRT in their practice settings. Lastly, we thank the many members of our Policy Steering Committee, Technical Assistance Provider JBS International, and our SAMHSA project officers Audene Watson, Reed Forman, Robert Day, and Andrea Harris.

Virginia Department of Behavioral Health & Developmental Services

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A Division for Advancing Prevention & Treatment
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George Mason University

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Sinclair Health Clinic

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Mission

The history of substance misuse in the United States is long and complex, with a multitude of factors contributing to the availability and misuse of licit and illicit substances. Addressing the impact of such use on individuals, their families, and their communities has been a priority of federal agencies for quite some time. In 2016, the Substance Abuse and Mental Health Services Agency (SAMHSA) issued one of many funding announcements to address the impact of substance use through its Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant program. This SBIRT grant program was designed to support state agencies in expanding and/or enhancing the continuum of care for Substance Use Disorder services to reduce alcohol and other drug consumption, reduce its negative health impact, increase abstinence, reduce costly health care utilization, and promote the integration of sustainable behavioral health and primary care services through the use of health information technology. It also sought to identify and sustain systems and policy changes to increase access to treatment in generalist and specialist settings and increase the number of individuals accessing services through technological means.

In the fall of 2016, the Commonwealth of Virginia's Department of Behavioral Health and Developmental Services (DBHDS) was **awarded a five-year SBIRT grant to enhance the continuum of substance use services throughout the state called the Virginia SBIRT Project.**

Project Mission

The mission of the Virginia SBIRT Project was to change the trajectory of substance use and depression through early identification and intervention, preventing the onset of negative sequelae for those in the beginning stages of substance misuse and mitigating further harm for those in more advanced stages.

Project Goals

1. Increase access to universal screening, secondary prevention, early intervention and treatment for people engaging in substance misuse or abuse by implementing SBIRT in primary care and community health settings through both onsite and technological means.
2. Develop a systematic training model that efficiently and effectively promotes needed clinical skill learning, practice competency and fidelity in SBIRT evidence-based practices to a wide scope of healthcare providers through webinars, courses, onsite coaching/feedback and clinical toolbox resources.
3. Ensure a sustainable VA-SBIRT model within Virginia's healthcare system.

Mission

Project Goals (continued)

The following is a summary of how the Virginia SBIRT Project achieved these goals.

1. Increase Access to SBIRT in a Variety of Settings Using Onsite and Technological Means

The Virginia SBIRT Project supported the integration of SBIRT into 13 medical settings and 6 mental health agencies. While sites varied in their approach to SBIRT, they all incorporated both on-site and electronic tools to facilitate service implementation. Electronic means were used primarily in support of the screening process where patients were screened either via survey link on a tablet device or electronic health record portal.

Collectively, Virginia SBIRT practice sites screened 104,391 Virginians between 2016-2021.

Overall risk prevalence was lower than national norms although variation was observed across setting, with health department sexually transmitted infection clinics seeing the highest risk rates (16% overall risk compared to 6-8% overall risk for other settings).

Depression risk also varied by setting, with clinics serving the under- and uninsured as well as primary care clinics seeing the highest rates of depression risk (20% and 17% overall risk, compared to 8% in other settings).

- Practice site brief interventionists delivered **11,754 interventions for substance use and/or depression risk.**
- Notably, the Virginia SBIRT Project demonstrated change to individual trajectories of substance use and depression across populations of all ages 18 and over and in a variety of settings across several regions of Virginia.
- Based on a random 10% sample of people receiving services, **SBIRT interventions effectively decreased alcohol use, illicit drug use, and depression.**

Mission

Project Goals (continued)

One of every 2 (50%) individuals who received an intervention for risky alcohol use were either:

36%

within recommended drinking limits 6 month later, or

14%

had decreased their level of risk.

27%

Over a quarter of the sample eliminated binge drinking.

Two of every 5 (39%) individuals who received an intervention for risky drug use were either:

32%

abstinent 6 months later, or

7%

had decreased their level of risk

Seven of every ten (71%) individuals who received an intervention for depression were either:

55%

at no risk, or

16%

had decreased their level of risk

The Virginia SBIRT project demonstrated that SBIRT **does work** and that people are comfortable with SBIRT services. Individuals receiving interventions overwhelmingly endorsed feeling comfortable discussing their use and felt staff were respectful toward them.

3 out of every 4 individuals (73%) indicated they found the SBIRT related discussions very helpful or helpful.

"Appreciated the facts given and the fact that [SBIRT clinician] was very non-judgmental and down to Earth. Felt like I could talk to [SBIRT clinician] about anything."

SBIRT Participant

Mission

Project Goals (continued)

2. **Develop a systematic training model**

The VA-SBIRT Training Team prepared healthcare professionals and support staff at practice sites to develop competency and confidence to implement SBIRT through **provision of knowledge sharing, skills training, and coaching.**

Training Topics Included

- *SBIRT Evidence-Based Practices*
- *Behavioral Health Integration*
- *Workflow Implementation*
- *Documentation*
- *Data Collection*

Training curriculum for interventionists Included

- *Exposure to new concepts (self-paced webinars, self-directed readings)*
- *Immersion into new skills (experiential workshops, role playing)*
- *Competency development (in-person individualized coaching, learning collaborative).*

Mission

Project Goals (continued)

3. Ensure a Sustainable VA-SBIRT Model Within Virginia's Healthcare System

The Virginia SBIRT Project intentionally designed its implementation approach and work with practice sites to boost the likelihood of sustainable SBIRT services. Common facilitators and barriers to sustainability were identified in early discussions with practice sites and helped to inform the implementation model with the highest likelihood for sustainability.

Key Domains for Sustainability Included

- *Environmental Support*
- *Funding Stability*
- *Partnerships*
- *Organizational Capacity*
- *Program Evaluation*
- *Program Service Design*
- *Communications*
- *Strategic Planning*

Key stakeholders at practice sites were prepared on the basics of the implementation process to be able to manage ongoing SBIRT workflow deviations and needs. Training sustainability occurred through a Train the Trainer process.

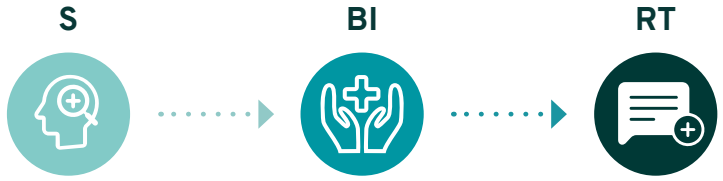
To support the wider uptake of SBIRT across Virginia, no-cost training and technical assistance in SBIRT was offered to healthcare providers working outside of participating practice site locations throughout Virginia.

At the conclusion of the Virginia SBIRT Project, 8 of 13 healthcare sites and all 6 mental health agencies had sustained SBIRT.

- Two sites stopped SBIRT operations following the pandemic due to their healthcare locations transitioning into COVID testing and treatment sites.
- Two sites sustained for some time and then operations halted when significant turnover throughout their settings resulted in few to no SBIRT champions prepared to embrace SBIRT and support implementation and/or training.
- One site launched SBIRT and stopped operations midway through their funding period due to competing priorities of staff.

History

In 2016, the Commonwealth of Virginia's Department of Behavioral Health and Developmental Services (DBHDS) was awarded a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the integration of SBIRT (Screening, Brief Intervention, and Referral to Treatment) into healthcare settings throughout the Commonwealth. This award presented DBHDS with **the opportunity to accelerate substance use identification, secondary prevention, and treatment efforts** during a time when the nation's third wave of the opioid epidemic had reached a crises level.



DBHDS strategically identified a variety of healthcare settings where opportunities for early identification and intervention for substance use would reach the most people, and some of the highest risk groups of people – young adults and people engaging in high-risk sexual behavior.

Settings Included

- *Emergency and Urgent Care Services*
- *Primary Care*
- *Federally Qualified Health Centers*
- *Free Healthcare Clinics*
- *University Student Health Clinic*
- *Health Department Sexually Transmitted Infection Clinics*

To support the execution of this project, DBHDS established programmatic partnerships with A Division for Advancing Prevention and Treatment (ADAPT) at the Center for Drug Policy and Prevention and The University of Baltimore, George Mason University, and the Center for Behavioral Health Integration to oversee, implement, and evaluate this initiative. These agencies worked collaboratively to plan, execute, evaluate, and complete the Virginia SBIRT Project, in alignment with the primary mission to increase identification, early intervention and treatment of substance misuse and depression in Virginians ages 18 and older.

Changing lives one screen at a time…

What is SBIRT?

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based public health approach for the **early identification** and **early intervention** of substance misuse and co-occurring problems. As an upstream approach, the SBIRT model aims to identify substance misuse as it is emerging so that an appropriate intervention can be offered to assist people in decreasing their risk of developing a Substance Use Disorder (SUD) and decrease the impact of negative consequences linked to substance use.

SCREENING

Screening is the first step in the SBIRT framework. Where possible, this includes universal screening of all people in a given setting.

Substance Use Screening

- *Alcohol*
- *Licit and Illicit Drugs*
- *Tobacco*
- *Nicotine*

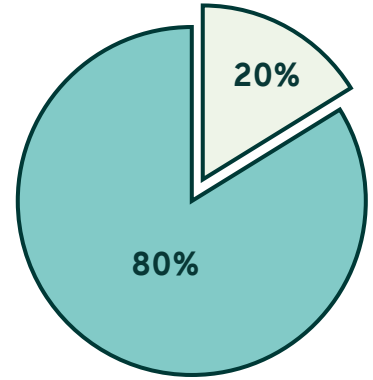
Mental Health Screening

- *Depression*
- *Anxiety*

Primary Universal Screening - Substance Risk

80% of people screened in a general community setting will screen negative to substance risk; no further action necessary.

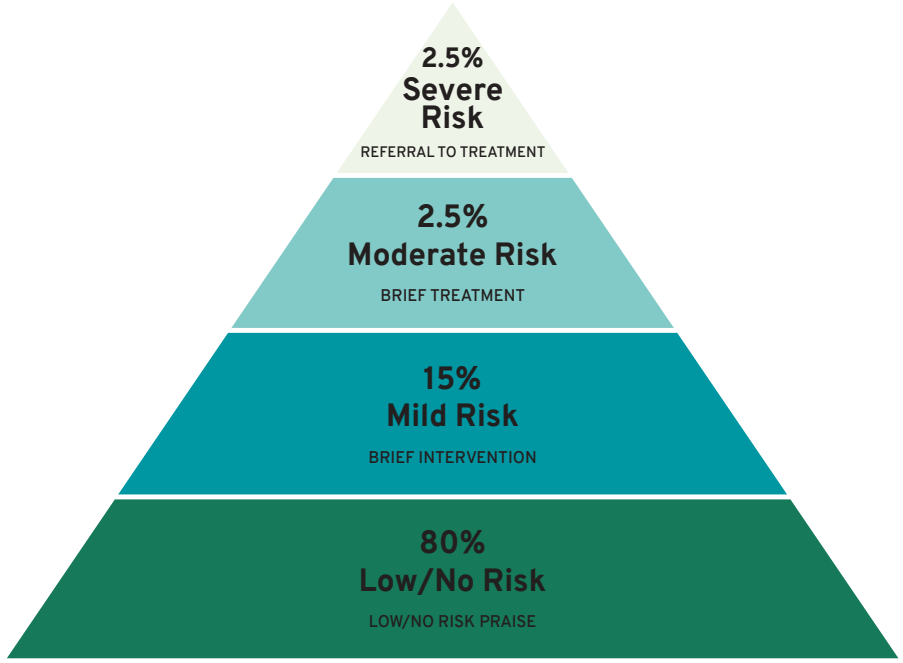
20% of people screened in a general community setting will screen positive to substance risk; secondary screening necessary.



The SBIRT Framework

SCREENING

A key function of the SBIRT framework is identifying and stratifying substance use risk into clinically meaningful categories that inform the most appropriate level of intervention for that level of risk. These risk categories range from Low/No Risk through Severe Risk. The SBIRT risk categories, indicated level of clinical intervention, and Virginia SBIRT prevalence rates for each level of risk are shown here.

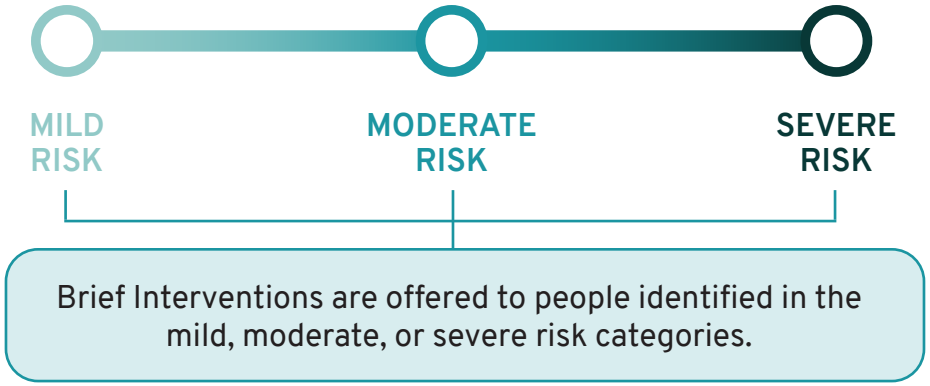


Secondary Screening

When a universal screen is positive, a secondary screen is administered. The vast majority of people who complete a secondary screen will fall in the mild risk category. This is where people are using substances and often just beginning to experience negative problems linked to their use. **Intervening when someone is at this low risk range, to help individuals take action before patterns of use worsen and problems worsen is the core of what the SBIRT framework strives to do.** A smaller number of people will fall into the moderate or severe risk categories. Those who screen at a severe risk level are likely to meet diagnostic criteria for a SUD.

The SBIRT Framework

BRIEF INTERVENTION



Mild + Moderate Risk

For those at mild and moderate risk levels, the Brief Intervention is typically a 5-10 minute conversation that aims to increase awareness of substance misuse and any associated consequences, provide feedback and education, explore and enhance readiness to change, and develop a plan to lower ones risk. The Brief Intervention is heavily informed by a Motivational Interviewing approach in which the provider skillfully dialogues with the at-risk individual in a way that is likely to activate that individual toward making a change.

Moderate + Severe Risk

When people screen at moderate and severe risk levels, the goals of the brief intervention remain the same with an added emphasis on working to help the at-risk individual to be open to accepting a referral for further assessment and treatment.

"Made me start to think about getting things under control. They offered assistance, all I had to do was ask. They did not make me feel embarrassed."

SBIRT Participant

"The conversation brought certain things to my attention and made me look back at some decisions I'd made. It helped me gain perspective and make better decisions."

SBIRT Participant

The SBIRT Framework

REFERRAL TO TREATMENT

The third step in the SBIRT framework, Referral to Treatment, refers to an active and collaborative approach to the referral process. This may include planning around the facilitators and barriers to accepting the referral, developing relationships with common referral sites to streamline the transition, and instituting follow up as a standard of care.

Moderate Risk

SBIRT sites with the capacity to offer ongoing counseling or therapy are encouraged to offer on-site Brief Treatment services. People who fall in the moderate risk range would often benefit from a higher level intervention than a single or multiple brief interventions yet their severity may not make them appropriate for referral to a specialty SUD treatment facility. These individuals are often better suited to outpatient treatment – 6-12 sessions of outpatient weekly or biweekly counseling. SAMHSA has created a treatment manual to support the delivery of Brief Treatment, called Integrated Motivational Interviewing and Cognitive Behavioral Therapy *(See Appendix 9)*.

Severe Risk

Based on their screening scores, people who fall in the Severe Risk range are likely to meet diagnostic criteria for a SUD. This level of risk would be best served by diagnostic assessment of their substance use and treatment within a setting that offers specialized SUD treatment. Treatment at this level of risk may include counseling and other psychosocial rehabilitation services, medications, involvement with self-help and recovery supports, or some combination of these approaches. Treatment intensity may range from traditional or intensive outpatient programs, residential treatment, and inpatient or detox services.

The active and collaborative approach to the referral process is designed to capitalize on an individual's motivation to change and engage in treatment by making the transfer of care easier and more timely. Through established relationships with referring treatment providers and referral agreements specifying strategies to support the transfer of care, providers are able to increase the likelihood that their referral will result in treatment initiation at the referring practice.

The SBIRT Model

REFERRAL TO TREATMENT

Severe Risk (continued)

An essential ingredient to this transfer of care is the warm handoff. **A warm handoff referral is the action by which a provider directly introduces or links their patient to another treatment provider via face-to-face or phone transfer at the time of the visit.** The rationale behind the warm handoff referral is that the direct contact to a referring provider will confer the trust and rapport established between the patient and their existing provider to the new provider. Face-to-face introductions may also increase the likelihood that subsequent appointments will be kept in situations in which the new provider is not able to see the patient that same day.

Sample scripts for engaging in warm handoffs can be seen on the right.

Sample Warm Handoffs

- *As a part of your overall health care, I'm concerned about your level of [alcohol/drug] use. I have a colleague down the hall that assesses these issues and I'd like you to meet with them today so I can provide you with the best care. Together we can develop a plan to deal with this. May I introduce you?*
- *It sounds like you might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it alright if I introduce you to them?*
- *[For Severe Risk Levels]: The way you answered the questionnaires on [alcohol/drugs] places you in what is called, "the severe range." People who score like this are likely experiencing health and social problems that are related to their [alcohol/drug use]. As your health care provider I would like you talk with my colleague who can take a closer look with you and see if there is anything we should be concerned about. May I introduce you to them?*

Why SBIRT?

SBIRT works. The SBIRT model is one of the most effective secondary prevention strategies available to healthcare providers. [1] While the most robust support for SBIRT exists for reducing and ceasing alcohol and tobacco use,[2,3] there is good and growing support for its effectiveness with illicit drugs.[4] SBIRT outcomes specific to depression are preliminary yet promising.[3]

Clinical Research Shows That SBIRT Can:

- Lead to decreases in substance use
- Lead to decreases in negative consequences often linked to use, such as accidents, injuries, and legal consequences.[3]
- Be cost effective in reducing short- and long-term healthcare costs based on cost-benefit analyses.[5, 6]

For these reasons, the U.S. Preventive Services Task Force has recommended alcohol and drug screening and behavioral counseling interventions in primary care.

Goals

The Virginia SBIRT Project launched with three goals that would support the project mission to increase identification, early intervention and treatment of substance misuse and depression in Virginians ages 18 and older by screening over 100,000 Virginians across rural and urban regions.

Increase access to universal screening, secondary prevention/ early intervention, and treatment for people engaging in substance misuse by implementing SBIRT in primary care and community health settings through both onsite and technological means.

Develop a systematic training model that efficiently and effectively promotes needed clinical skill learning, practice competency and fidelity in SBIRT evidence-based practices to a wide scope of healthcare providers through webinars, courses, onsite coaching/ feedback and clinical toolbox resources.

Ensure a sustainable Virginia SBIRT model within Virginia's healthcare system.

Virginia SBIRT Participating Practice Sites

The Virginia SBIRT Project is grateful to our healthcare partners who allowed us to work closely alongside them as they integrated SBIRT into their clinic settings.

Practice Sites Selection Factors

1. *Location in a high-need region of Virginia,*
2. *Interest in adopting SBIRT as an organizational strategy for substance use prevention and management, and/or*
3. *Serve a population at higher risk for substance use including sexually transmitted clinics or higher education students.*

During Virginia SBIRT's final year of operation, healthcare partnerships were established with community mental health clinics in support of a rapid implementation approach to SBIRT.

Participating Partners Include:

- *Crescent Counseling*
- *Diamond Counseling*
- *EMS of Virginia*
- *Family Insight, PC*
- *National Counseling Group*
- *Pathways Homes, Inc*

Participating Practice Sites Included:

Emergency, Urgent Care, and Primary Care Services

Winchester Medical Center
Warren Memorial Hospital
Page Memorial Hospital
Shenandoah Memorial Hospital
Southside Medical Center
Valley Health Urgent Care @ Rutherford Crossing
Valley Health Winchester Family Practice @ Rutherford Crossing

Federally Qualified Health Centers

Neighborhood Health
HealthWorks

University Student Health Clinic

George Mason University Student Health Center

Free Healthcare Clinics

Sinclair Health Clinic
Loudoun Free Clinic

Health Department STI Clinics

Prince William Health Distric
Fairfax Count Health Department

Implementation Approach

Virginia SBIRT practice sites integrated SBIRT into clinical workflows and electronic health records through 5 sequential practice transformation phases:

Orientation > Process Development and Sustainability Planning > Training > Implementation > Evaluation

Planning Phase (3 Months)

1. Orientation

Individual practice site meetings oriented teams to the rationale behind the importance of SBIRT, elicited commitment from senior leadership, and led to the formation of the planning/implementation change team (SBIRT champions).

2. Process Development and Sustainability Planning

Organizational readiness to integrate SBIRT and process mapping occurred to inform conversations around the best model for SBIRT sustainability within each site. The most sustainable SBIRT workflow was developed that incorporated, where relevant, modifications to electronic health record, billing and coding processes, and establishment of the referral to treatment process and network.

3. Training

Multilevel and ongoing training prepared behavioral health (counselors, social workers) and medical staff (physicians, nurse practitioners, physician assistants, nurses) to develop SBIRT proficiency. The comprehensive training program included an experiential workshop followed by coaching (observation with feedback).

Implementation Phase

4. Implementation

The SBIRT workflow was implemented in a pilot phase and then consistently and systematically fine-tuned to improve processes. Ongoing training needs were identified and booster training sessions as well as optional participation in a monthly teleECHO clinic promoting case sharing with feedback were offered.

5. Evaluation

Clinically meaningful and manageable evaluation metrics were identified and followed by ongoing Rapid Cycle Quality Improvement and evaluation process assessing program impact and provider experience.

Assessing Readiness and Building Engagement

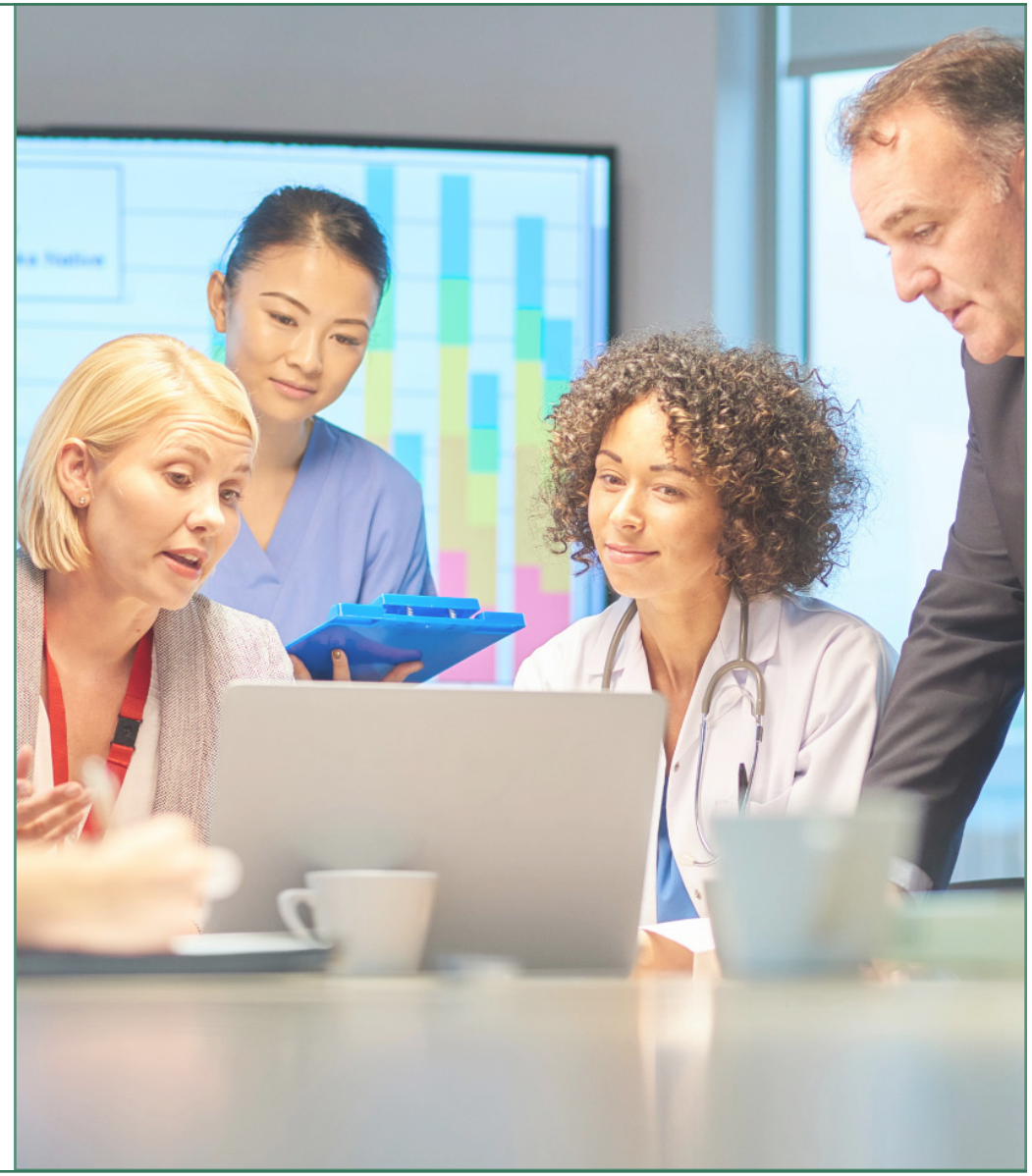
The Virginia SBIRT Project Team were all trained in Motivational Interviewing skills to support practice sites in building readiness, facilitating engagement, and addressing attitudinal barriers during the implementation process. To ground this process, a baseline SBIRT Implementation Readiness Survey was completed by key stakeholders from each practice site during the process development and sustainability planning phase of the project.

This survey included 28 items measuring each site's readiness to integrate each component of the SBIRT model into their medical setting and to identify barriers and facilitators to integration.

The Project Team used the information obtained from the readiness assessment, along with observations of clinical operations, to develop site-specific implementation plans.

Implementation Plans Included:

- *Identification of the Implementation/Change Team (SBIRT Champions)*
- *Policy updates to support SBIRT integration*
- *Clinical/data collection workflows*
- *Training plans*
- *EHR integration*
- *Fiscal sustainability plans*



Clinical Workflows

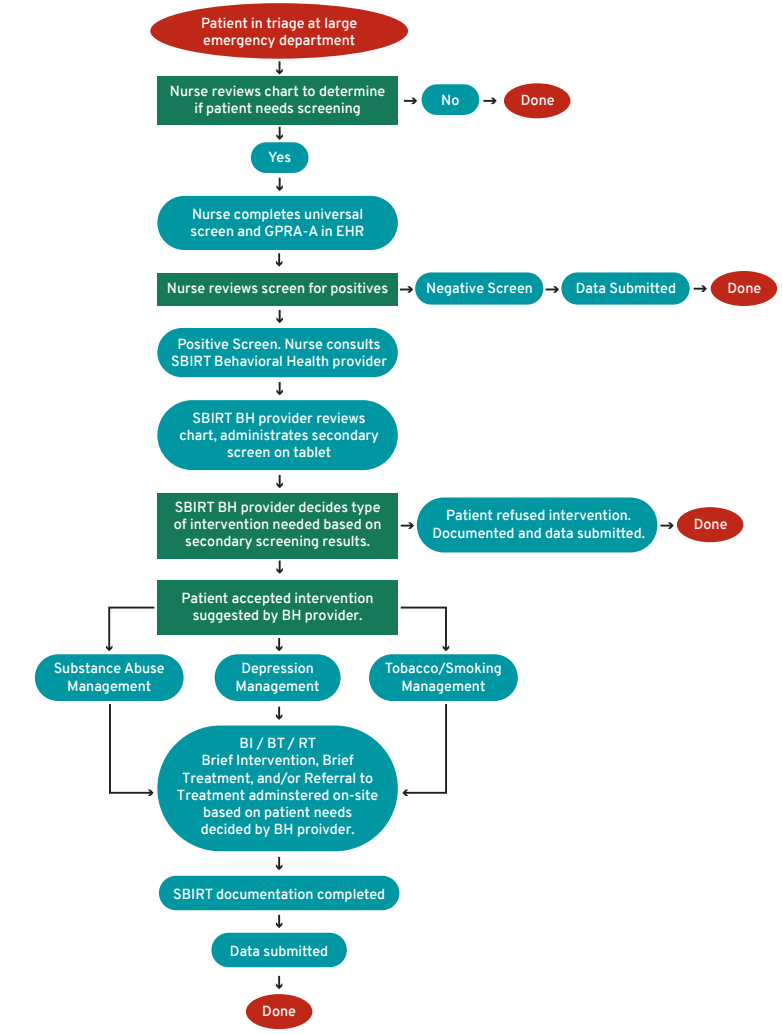
The development of clinical workflows was an iterative process in which the Project Team worked with partner sites to determine the most effective and efficient way to map SBIRT clinical and data collection requirements onto existing clinical operations. Various models for SBIRT implementation were reviewed with the sites to determine the most feasible and acceptable model based on existing operations and reimbursement structures.

The Project Team participated in on-site observations and integrated data from the SBIRT Implementation Readiness Survey to create the clinical workflow. All clinical workflows and role assignments to SBIRT functions were determined to be the most sustainable approach that would also facilitate the greatest ease for implementation.

Across practice sites, clinical workflows varied in two key areas:

1. *Degree of EHR or technological integration*
2. *Role assignments for universal screening, secondary screening, brief intervention, brief treatment, and referral to treatment.*

Sample Workflow: Large Emergency Department



Sustainability Planning

The Virginia SBIRT Project was launched with a focus on sustainability so that practice sites would be able to continue effective SBIRT delivery upon conclusion of grant funding.

From the outset, early conversations with partner sites included discussions about how to most strategically integrate SBIRT in a way that would promote the greatest success of sustainability. Common barriers to sustainability, such as lack of leadership buy in or funding were addressed throughout the implementation process in effort to support addressing sustainability barriers. Key stakeholders at practice sites were prepared on the basics of the implementation process to be able to manage SBIRT workflows.

Training sustainability occurred through the Train the Trainer process. In their final year of funding, stakeholders from each practice site met with the Project Team to review key sustainability domains and to develop support plans, where needed, to address risks to sustainability.

Domains for SBIRT sustainability addressed during planning discussions were derived from the SBIRT Sustainability Assessment Tool.

Domains Include:

Screening Tools & Intervention Models

SCREENING

The Virginia SBIRT Approach to screening included universal screening for alcohol, tobacco/nicotine, licit and illicit drugs, and depression. Positive endorsements on alcohol, drugs, and depression resulted in a secondary screen to stratify risk into severity categories. Depression was included in the screening process given the high co-occurrence between substance use and depression.

Universal Screening Categories:

ALCOHOL

The first three consumption items of the US Alcohol Use Disorders Screening Test – Consumption (US AUDIT-C) was used to universally screen for alcohol. Risk positive scores on the US AUDIT-C triggered completion of the secondary screen, the remaining 7 items of the US AUDIT.[7]

TOBACCO/NICOTINE

A single frequency-based nicotine/tobacco item was used to universally screen for current use of nicotine/tobacco products. No secondary screening was completed for these substances.

LICIT AND ILLICIT DRUGS

Given the changing socio-political landscape around cannabis products and the high rate of opioid use in Virginia, project stakeholders wanted more information regarding prevalence rates of use of these substances. Therefore, the project adapted the National Institute on Drug Abuse (NIDA) Quick Screen to universally screen for four categories of licit and illicit drug use: cannabis, misuse of prescribed drugs, prescription drug use for nonmedical reasons, and any other illicit drug use. Any positive risk endorsement on the licit/illicit drug use universal screen led to secondary screening using the Drug Abuse Screening Test, 10-item version (DAST-10).[8]

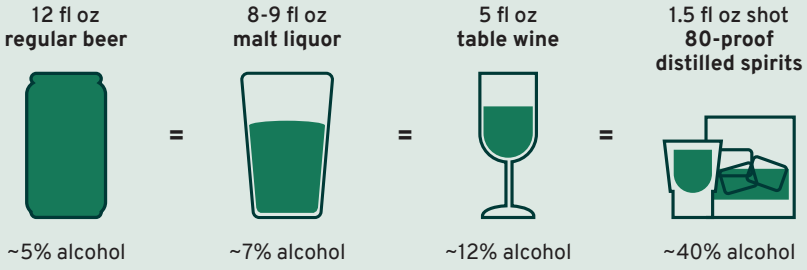
DEPRESSION

The first two items of the Patient Health Questionnaire (PHQ-2) was used to universally screen for depression. Risk positive scores on the PHQ-2 triggered completion of the secondary screen, the remaining 7 items of the PHQ (PHQ-9).[9]

See Appendix 2 for the full Virginia SBIRT Screening Instrument Library.

Standard Drink Equivalences

When screening for alcohol use, clarifying drink equivalencies is critical to assess the amount of drinks consumed. Staff are provided with training and drink equivalency tools such as the one provided here to assist them in the screening process.



Screening Tools & Intervention Models

Intervention Models

Virginia SBIRT practice site teams were trained to implement a set of evidence-base practices for effective delivery of the SBIRT Model. These included Motivational Interviewing, the Brief Negotiated Interview, Brief Behavioral Activation, Integrated Motivational Interviewing and Cognitive Behavioral Therapy, and Active Referral to Treatment.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is widely recognized for facilitating decision-making and behavior change with a robust literature showing it leads to greater rapport, desire and commitment to change, actual behavior change[10], and treatment engagement/retention.[11,12] Practice site providers received basic MI skills training to support efficacy of screening, delivery of Brief Interventions and Brief Treatment, and referral acceptance. MI also served as one of the foundations for addressing attitudinal barriers and obstacles while engaging stakeholders, leaders, staff, and community partners throughout the project implementation process.

BRIEF NEGOTIATED INTERVIEW

The Brief Negotiated Interview (BNI) was used as the intervention model for Brief Interventions for substance risk. The BNI is a semi-structured algorithm that helps providers explore health behavior change with patients respectfully and non-judgmentally within 5-10 minutes.[13,14] Rather than telling patients what changes they should make, the BNI elicits reasons for change and action steps from the patient. It gives the patient voice and choice, making any potential behavior changes more empowering to the them. For those with negative substance screens, the BNI guides the provider to deliver anticipatory guidance that reinforces the decision not to use. While Brief Interventions were most commonly delivered as a single, same-day intervention, providers were encouraged to set follow-up appointments or deliver outreach calls to offer additional BIs as clinically indicated.

BRIEF BEHAVIORAL ACTIVATION

Brief Behavioral Activation for depression was used as the Brief Intervention model for depression risk. Similar in structure to the BNI, Brief Behavioral Activation is a semi-structured algorithm that helps providers identify opportunities to promote patient activation towards value-based pleasure and mastery activities to decrease depression.[15]

INTEGRATED MOTIVATIONAL INTERVIEWING AND COGNITIVE BEHAVIORAL THERAPY

Integrated Motivational Interviewing and Cognitive Behavioral Therapy (ICBT) served as the Brief Treatment intervention model. ICBT integrates two gold standard therapies with robust evidentiary support for treating adult Substance Use Disorder and co-occurring disorders – Motivational Enhancement Therapy[16] and Cognitive Behavioral Therapy.[17] ICBT is an brief, time-limited outpatient treatment that targets building and sustaining motivation while teaching intra-personal, interpersonal, and social support skills for reducing substance and mental health risk.

ACTIVE REFERRAL TO TREATMENT

Active Referral to Treatment (ART)[18] is an assertive and collaborative approach to care navigation that includes working with patients to explain the necessity for and process of referral, identify treatment resources, facilitate healthcare acquisition, identify and work to remove barriers to accepting referrals, and conduct warm handoffs. To facilitate ART, referring providers became knowledgeable of local treatment and support resources and established referral agreements with partner treatment agencies.

The Virginia SBIRT Training Plan

The VA-SBIRT Training Team worked to prepare healthcare professionals and support staff at practice sites to develop competency and confidence to implement SBIRT by providing skills training and coaching for all levels of clinical and administrative personnel.

Training Topics Included

- *SBIRT Evidence-Based Intervention Models*
- *Behavioral Health Integration*
- *Workflow Implementation*
- *Documentation*
- *Data Collection*

Diverse Training Methods Employed and Included

- *Self-Paced Webinars*
- *Skills Workshops*
- *Self-Directed Readings*
- *In-Person Individualized Coaching*
- *A Learning Collaborative*

As SBIRT is a skill, experiential approaches were emphasized to provide trainees the opportunity to practice and receive feedback on implementation. Training materials and approaches were designed to increase knowledge, develop skills proficiency, and instill confidence in skills delivery.

The project Training Coordinator worked with each practice site to assess training needs and customize the training plan to meet those needs. This included adapting trainings based on the incoming knowledge and skills of the providers.

For example, where providers had no previous training in Motivational Interviewing, additional time was spent training on this topic.

The core training plan and sequence is provided on the following pages.

The Virginia SBIRT Training Plan: Core Training Plan

Clinical Skills Training

TRAINING TOPIC	LENGTH	PRESENTER	TARGETED AUDIENCE
Intro to SBIRT	1 Hour	Trainer	All Staff
SBIRT Online Course	4-5 Hours	Self-Initiated	Recommended for All Staff doing Brief Intervention; Required for new SBIRT hires
Motivational Interview/ Behavioral Intervention Online Course	1-1.5 Hours	Self-Initiated	Alternative for Medical Providers taking SBIRT training but not primarily responsible for Brief Interventions
SBIRT Core Curriculum			
SBIRT 101: Screening Tool Proficiency	1.5 Hours	Training Coordinator	Staff/providers performing Screening and/or Brief Intervention; Front Desk staff or other staff handing out screens
SBIRT 102: Motivational Interviewing and the BNI; Eliciting acceptance to Brief Treatment, Referral to Treatment, & Follow-up	1.5 Hours	Training Coordinator	Providers performing Brief Intervention
SBIRT 103: Referral to Treatment	.5 Hours	Training Coordinator	Providers performing Brief Intervention &/or case management

TRAINING TOPIC	LENGTH	PRESENTER	TARGETED AUDIENCE
Behavioral Activation as a Brief Intervention	1 Hour	Training Coordinator	Providers performing Brief Intervention for Depression
Integrated Care	1 Hour	Trainer	All New Behavioral Health SBIRT Providers
Brief Treatment: Integrated Motivational Interviewing and Cognitive Behavioral Therapy Therapy (ICBT)	6 Hours x 2 Days	Training Coordinator	SBIRT Brief Treatment Providers

The Virginia SBIRT Training Plan: Core Training Plan

Implementation Preparation

TRAINING TOPIC	LENGTH	PRESENTER	TARGETED AUDIENCE
Workflow, introducing screen to patients (preferred language, instructions on completing screen, queries about the process or screen items), developing system to track and review screening-eligible patients.	1.5 Hours	Training Coordinator	Front Office Staff
Workflow, warm handoff, time management, process to follow in absence of Behavioral Health clinician.	1.5 Hours	Practice Coordinator	MAs/Nursing Staff NOT Delivering Brief Intervention
Implementation (i.e., integrated Behavioral Health, workflow, documentation)	2 Hours	Practice Coordinator	Brief Intervention Providers
Grant Data Collection	Varies by Site	Data Manager & Training Coordinator	Staff involved in data collection

Following initial baseline training, providers were asked to complete an SBIRT Perceived Competence and Readiness Assessment *(see Appendix 10)* to inform ongoing training needs.

Ongoing Training & Coaching

To bolster fidelity to the SBIRT model and effectiveness in its delivery, the VA-SBIRT Training Team provided ongoing assistance, troubleshooting, and coaching as well as booster training sessions.

TRAINING TOPIC	LENGTH	PRESENTER	TARGETED AUDIENCE
On-site Coaching	Varies	Training & Practice Coordinator	Staff/Providers performing Screening or Brief Intervention
Monthly Brief Intervention TeleECHO Calls	1 Hour	Training Coordinator	Brief Intervention Providers
Monthly Brief Treatment TeleECHO Calls	1.5 Hour	Training Coordinator	Brief Treatment Providers

Booster trainings were comprised of coaching (i.e., live observation with personalized feedback) and provider participation in a monthly SBIRT teleECHO clinic. Content for coaching sessions either came from observation of SBIRT delivery with an actual clinic patient or role-playing with a member of the SBIRT training team using a standardized patient case scenario. *Providers were given feedback based upon an SBIRT Adherence Checklist (see Appendix 10).*

The VA-SBIRT Booster Training activities occurred at set time intervals following a live, in-seat core curriculum SBIRT training. The coaching session timeline included baseline coaching within two weeks following core curriculum training and then monthly for 6 months. The SBIRT teleECHO clinic operated on a monthly basis. Attendance and frequency of provider case presentations were tracked, as were the didactic content areas presented in the clinic. *See Appendix 11 for Training Plans and a sample teleECHO clinic brochure.*

The Virginia SBIRT Training Plan: Training & Technical Assistance

Training Sustainability

To support training sustainability, an SBIRT Training of Trainers process was implemented to prepare representatives from participating practice sites in the delivery of SBIRT training within their agencies. Site trainers were eligible if they had previously received SBIRT training and regularly involved in SBIRT delivery. The Training of Trainers process included participation in a 6.5 hour workshop and, where feasible, having a member of the Training Team co-train alongside a site trainer in their delivery of the training.

The Training Workshop Structure Allowed For:

1. *Training Team review of effective strategies for training to the SBIRT training modules.*
2. *Teach back sessions in which site trainers delivered sections of the training.*
3. *Training Team feedback on teach back sessions geared toward improving training delivery and increasing confidence in the training role.*

Rapid Implementation and Training Support

In the final year of the Virginia SBIRT Project, the Project Team piloted an accelerated SBIRT implementation and training protocol, titled Rapid Implementation and Training Support (RITS). RITS was designed to provide a select number of organizations with training and implementation support on a truncated timeline of four months. The process of implementation covered the same essential domains as with our practice site partners who received multi-year support:

- *Orientation*
- *Training*
- *Process Development and Sustainability Planning*
- *Implementation*

RITS allowed a number of sites to quickly establish their SBIRT program yet the timeline did not allow for the Project Team and participating sites to engage in ongoing continuous quality improvement.

The Virginia SBIRT Training Plan: Training & Technical Assistance

Statewide Training & Technical Assitance

In support of project goals to advance SBIRT across the state, the Virginia SBIRT Project Team provided no-cost training and technical assistance to healthcare providers working outside of participating practice site locations. Nearly all requests for training and technical assistance fell into the training domain. The Training Team designed and provided trainings responsive to the needs and requests received.

Training Topics Included:

- *SBIRT for Adolescents*
- *SBIRT for Pregnant and Post-Partum Women*
- *SBIRT for Marijuana Use*
- *SBIRT for Opioids*
- *Basic Micro Skills of Motivational Interviewing*
- *SBIRT for Beginning Motivational Interviewing Skills*
- *SBIRT for Intermediate Motivational Interviewing Skills*
- *Using Motivational Interviewing to Improve Health Outcomes During COVID-19*

The Virginia SBIRT Training Plan: Training Outcomes

In total, there were 970 attendees across all SBIRT trainings offered with 421 being from core implementation sites, 192 from rapid implementation sites, and another 357 who attended virtual trainings offered during COVID. Individuals who attended included the following range of professional roles:

- *Front Office Staff*
- *Medical Assistants*
- *Case Managers*
- *Community Health Workers*
- *Nurses*
- *Nurse Practitioners*
- *Physicians*
- *Physician Assistants*
- *Mental Health & Substance Abuse Clinicians*
- *Peer Support Staff*
- *Pharmacists*

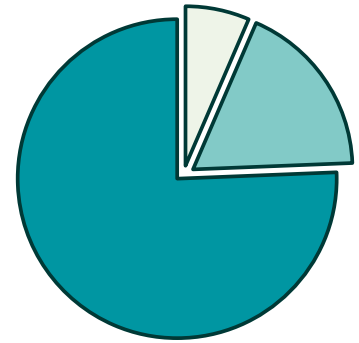
Staff from the core implementation sites (n=421) were asked to rate their knowledge and readiness to implement the different components of the SBIRT process post-training.

Prior To Receiving SBIRT Training:

76% of participants indicated they had no to only a little familiarity with the SBIRT process

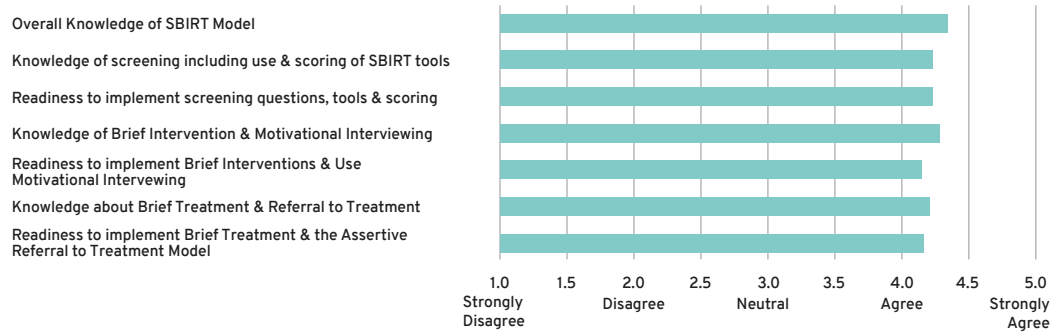
18% of participants had some familiarity

6% of participantshad quite a bit to a lot of familiarity



As is shown in the figure below, post training, participants overwhelmingly reported high levels of knowledge about different components of the SBIRT model as well as a strong sense of readiness to implement the model.

Average Ratings on Knowledge and Readiness to Implement SBIRT Post-Training



Continuous Quality Improvement Process

Continuous Quality improvement (CQI) efforts were factored into practice sites' implementation of SBIRT from the beginning. The broad implementation goals for SBIRT included universal screening and ensuring those identified with risk received appropriately matched interventions. Data dashboards were created for each site with these targets in mind yet tailored to how each site was implementing SBIRT. As dashboards were shared with practice sites regularly (every 2 weeks to quarterly depending on the site), key areas for improvement were identified. Practice site staff then determined opportunities for change in their workflow and/or practice, creating action steps during the CQI meeting. These steps would be reviewed in subsequent CQI meetings along with the most recent data dashboard to assess for improvement.

For example, in one practice site, rates of intervention with individuals positive for cannabis use were lower compared to those positive for risky alcohol or other drug use. Further investigation determined that often, the cannabis users scored in the mild risk range (requiring a brief intervention). Consequently, the staff reported challenges in engaging in brief interventions with this particular patient group. In addition, some staff did not necessarily perceive potential risk. Efforts were made to engage the practice site into more focused training on how to respond to cannabis use using the SBIRT framework.

In a second site, concerns were raised regarding the transition process from the staff performing the universal screens to the SBIRT clinician(s) (see chart below). The CQI process focused on tracking data regarding the number of positive screens and of those, the number of times a call or consult was made to the SBIRT clinician(s). The head nursing staff attended the CQI calls, helped to review the data and from there, strategies were developed to increase the consult rate if and when it was lower.

Calls/Consults Made to SBIRT

(Total patients seen within SBIRT hours)		All Positive Patients	# of Calls / Consults Made	% Calls / Consults Made
Raw Numbers	5/31/20 - 6/13/20	167	163	98%
	6/14/20 - 6/27/20	210	181	86%
	Since SBIRT Began	19812	11514	58%

COVID-19 Impact & Response

COVID-19 had a significant impact on project operations resulting in a range of outcomes, from modified protocols to shutting down of SBIRT operations entirely. Across all sites standard COVID protocols were put in place that included protective personal equipment and more sanitizing of shared supplies/spaces. Sites also uniformly reported lower census numbers resulting in fewer people screened compared to typical screening volume. So while fewer screens and brief interventions were being performed, practice sites observed a significant uptick in requests for, and compliance in regularly attending, Brief Treatment appointments. This transition was largely a function of shifting to telehealth delivery of treatment, thereby making this service more accessible.

A subset of sites were impacted more significantly and resulted in a partial or complete cease of SBIRT operations.

- One site experienced significant delays in their electronic health record vendor's ability to activate the screening process via a patient portal and therefore had to rely on screening only in-person appointments when risk was suspected by the provider.
- Three sites were transitioned into COVID response sites dedicated to testing, treatment, and/or contract tracing.
- One of these sites was able to reinitiate SBIRT services before the conclusion of the project whereas two remained dedicated to COVID testing and treatment for their healthcare system.

Overview

Virginia SBIRT clinical services began in February 2017. Across the grant-funded period, SBIRT was implemented in nine health care entities across 19 locations including emergency departments, an urgent care center, outpatient primary care clinics, clinics for uninsured patients, a student health center, and county health department clinics to address sexually transmitted infections (STI). In addition, six community mental health clinics initiated a rapid implementation approach to SBIRT in the final year of the grant.

In total, 104,391 unique individuals were screened as a part of the Virginia SBIRT effort!

Evaluation data are designed to highlight numbers served, the population screened, intervention delivery and outcomes.

- Data in the current report comprise screenings from February 2017 through August 31, 2021 for the health care entities.
- The community mental health clinics were excluded as they were in the early phases of implementation during the last quarter of the grant.
- In addition, data from September, 2021 were excluded due to the timing of the report.

For the time period specified above, 204,675 total screens were conducted.

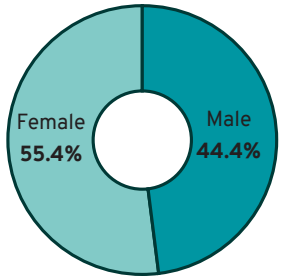
- Of these, **94,107 (46%) were unique individual screens.**
- **51,338 (25%) were rescreens** as it is recommended that individuals be rescreened annually although some providers elected to screen at every visit. If a patient was screened more than once, the screen in which they scored highest for risk and received the highest level of intervention is reported.
- **59,230 (29%) were screens conducted outside of SBIRT program hours.** Emergency Departments (EDs) operate 24 hours a day, 7 days per week. Because universal screening was built into their electronic health platform and due to their implementation protocols, screening occurs during all hours of operation. In the larger EDs, the SBIRT clinicians were available 9:30am to 9:30pm daily. Thus, there were times (9:30pm to 9:30am) patients were screened when there was no SBIRT team to provide interventions to patients positive for risk. The SBIRT clinicians attempted to follow up with those individuals by phone when able.

For this next section of the report that describes the population served and risk prevalence, the sample of unique individuals (94,107) was used.

Overview

Demographics of Individuals Served

Gender

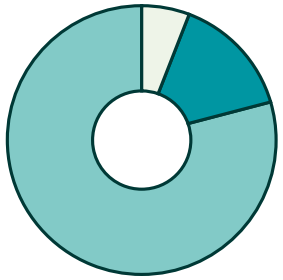


Transgender
0.1%

Other
0.1%

Missing
0.1%

Ethnicity



Not Latino/a/x
77.9%

Declined to answer or missing
17.1%

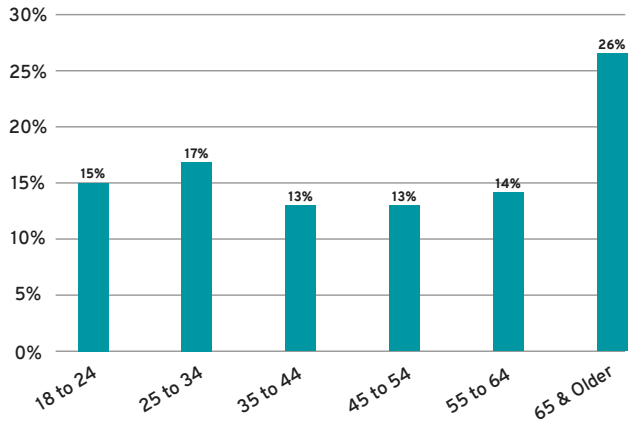
Latino/a/x
4.9%

Race

Alaska Native	**0.01%**
American Indian	**0.35%**
Asian	**3.00%**
Black	**7.25%**
Native Hawaiian	**0.18%**
White	**73.89%**
Missing	**16.06%**

Overall, 11% of individuals screened identified as Black, Indigenous or Persons of Color (BIPOC).

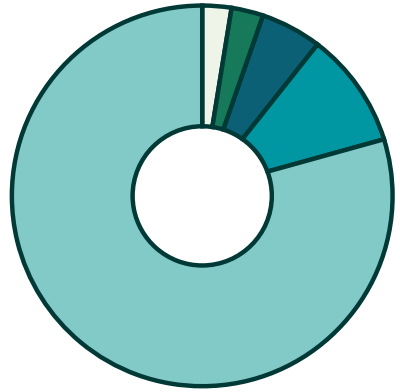
Age



Type of SBIRT Site

Below is a breakdown of the number of unique individuals screened by the type of medical site. The majority of screens occurred at a large health care system across three emergency departments/urgent care centers. The remaining 20% of screens occurred across a range of diverse outpatient, non-acute medical settings.

Emergency Department & Urgent Care Centers (ED & UC)	**75,130**
Primary Care Practices	**4,283**
Clinics for Uninsured Patients	**2,858**
VA County Health Departments	**2,561**
Student Health Services	**9,275**
Total	**94,107**



Emergency Department & Urgent Care Centers (ED & UC)
80%

Primary Care Practices
5%

Clinics for Uninsured Patients
3%

VA County Health Departments
3%

Student Health Services
10%

Tobacco Use

Overview

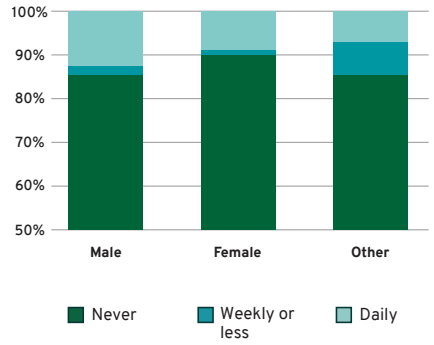
To screen for tobacco use, individuals are asked, **"In the past month, how often have you used tobacco?"**

While 21% of all individuals endorsed some tobacco use, there were differences by demographic factors.

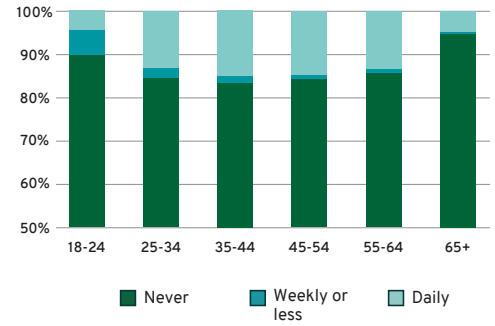
- Females endorsed lower rates of tobacco use. Although males and individuals who identified as transgender, nonbinary or other had comparable rates of any tobacco use, males were more likely to be daily or almost daily tobacco users.
- Rates of tobacco use were lower for young adults and older adults compared to all of the other age groups.
- For race, individuals who identified as Black or African American, White or more than one race had relatively higher rates of any tobacco use with the first two groups endorsing higher prevalence of daily or almost daily tobacco use.
- Those who identified as Latinx had lower rates of tobacco use overall. Primary care practices had lower rates of any tobacco use compared to other sites while clinics for uninsured individuals and the county health department STI clinics had the highest rates of tobacco use.

Tobacco Use: Demographics

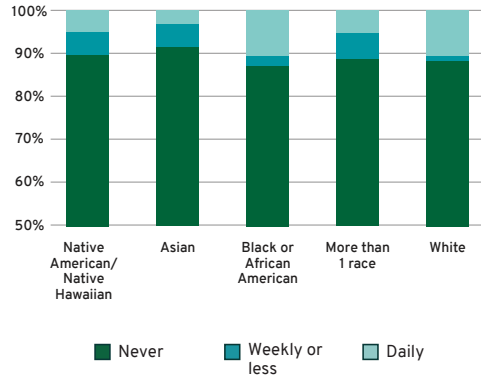
Tobacco Risk by Gender



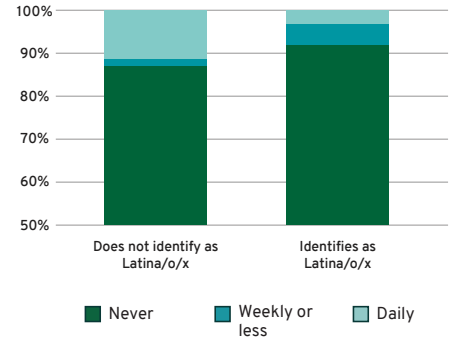
Tobacco Risk by Age



Tobacco Risk by Race



Tobacco Risk by Ethnicity



Note: The number of individuals who endorsed solely Native American or Native Hawaiian were small enough that in order to examine risk by identified race, they needed to be combined.

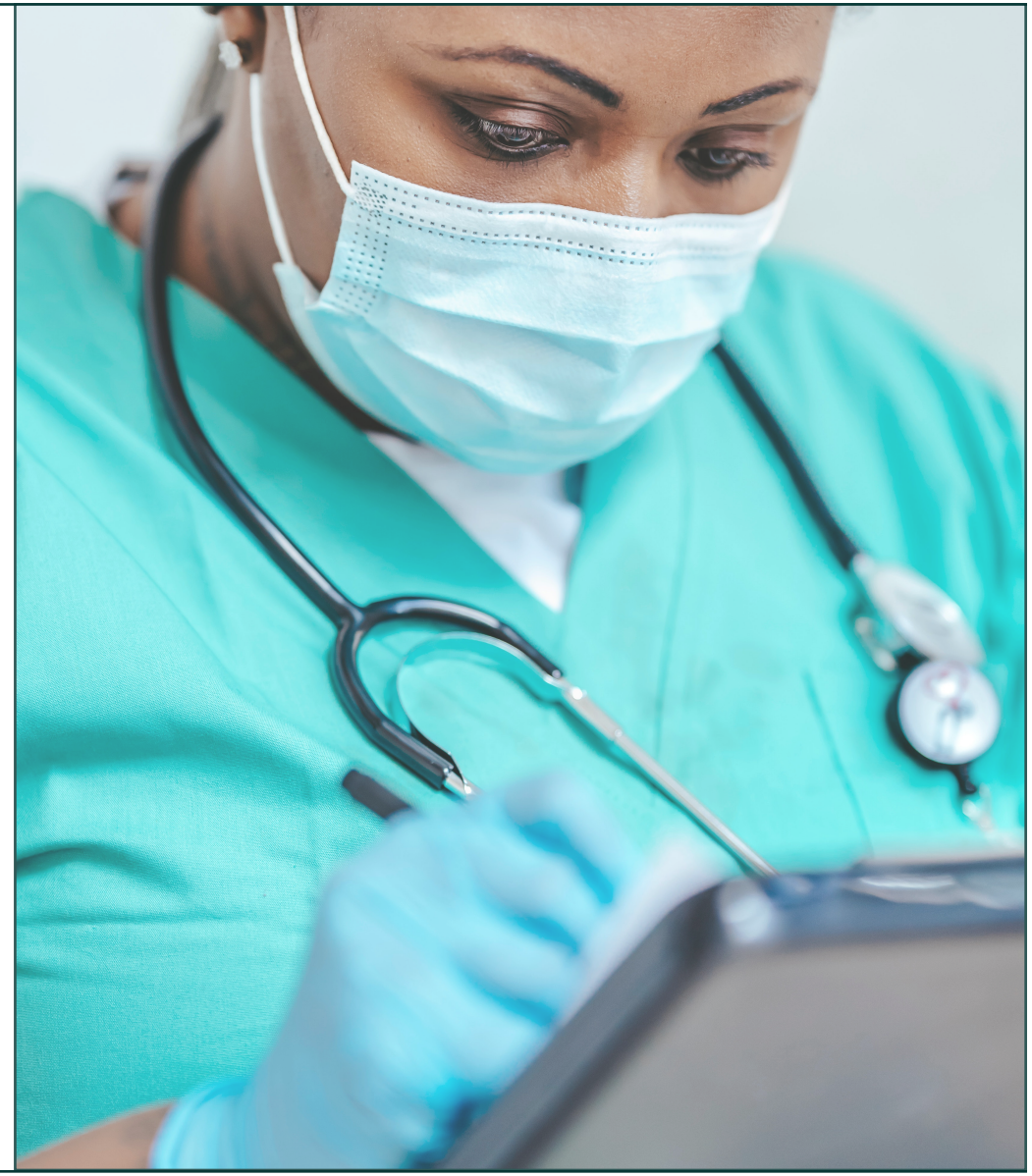
Tobacco Use

Tobacco Use: By Site Type

	Tobacco Usage by Site Type					
	Total Across All Sites	Emergency Dept. & Urgent Care	Primary Care Practice	Clinics for Uninsured	Health Dept.	Student Health Service
Tobacco Use	**21%**	**22%**	**14%**	**31%**	**28%**	**18%**

Across all sites, **4 out of 5** individuals who used tobacco, used it daily.

6 out of 10 individuals positive for risky alcohol, cannabis or other drug use also reported using tobacco.



Alcohol, Cannabis, and Other Drug Use

Overview

As part of the initial screening process, individuals are also asked about alcohol and other drug use. The US Alcohol Use Disorders Identification Test (US AUDIT) is used to screen for alcohol use. For drug use, specific questions are asked for marijuana, prescription drug misuse, and other illegal drug use followed by the ten item Drug Abuse Screening Test (DAST10). Responses on the US AUDIT and DAST10 are scored, allowing for risk stratification.

	Substance Use Risk by Medical Site Type				
	Emergency Dept.	Primary Care Practice	Clinics for Uninsured	Health Dept.	Student Health Service
Severe Risk	1%	1%	2%	2%	0%
Moderate Risk	2%	2%	2%	6%	1%
Mild Risk	8%	9%	13%	33%	16%
No Risk	89%	89%	83%	59%	83%

As seen above, the Virginia county health department sexually transmitted infection clinics had greater numbers of individuals with substance use risk compared to other types of medical sites, followed by student health and clinics that serve uninsured individuals.

Alcohol Use

Based on the administration of the US AUDIT, 6% of individuals were positive for risky use of alcohol. In looking at alcohol risk by demographic factors, the following differences were observed:

- Males and those who identified as transgender, nonbinary or other displayed higher levels of risk for alcohol use compared to females.
- Middle-aged adults 34 to 65 displayed the highest levels of alcohol risk.
- Individuals who identified as American Indian, Alaskan Native, or Native Hawaiian displayed higher levels of alcohol risk.

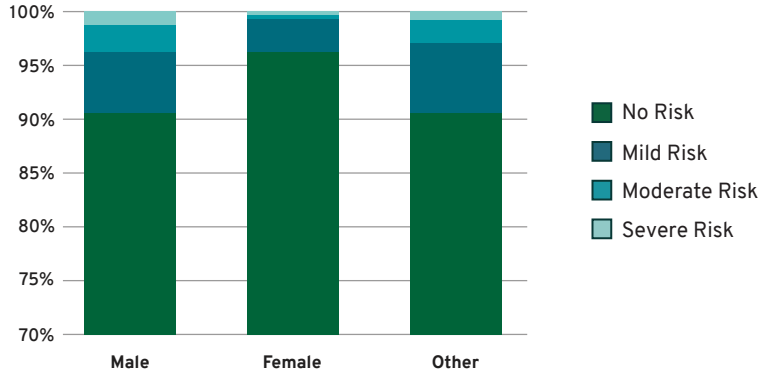
"I was aware of my alcohol use, but it [SBIRT] made me aware of the limits on how much I should and should not be drinking."

SBIRT Participant

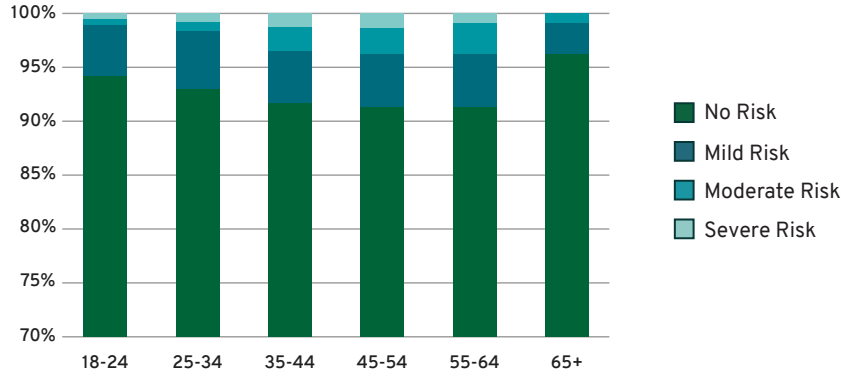
Alcohol, Cannabis, and Other Drug Use

Alcohol Use: Demographics

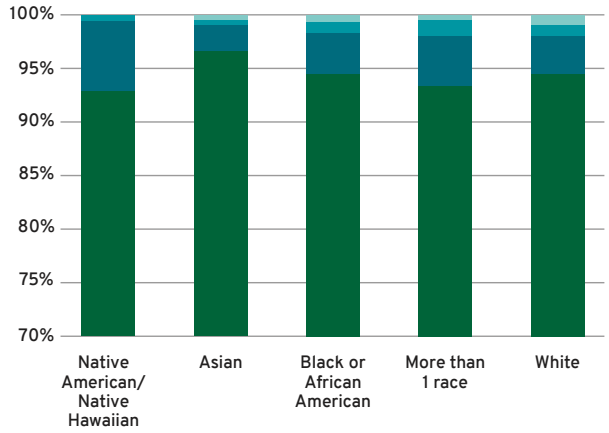
Alcohol Risk by Gender



Alcohol Risk by Age

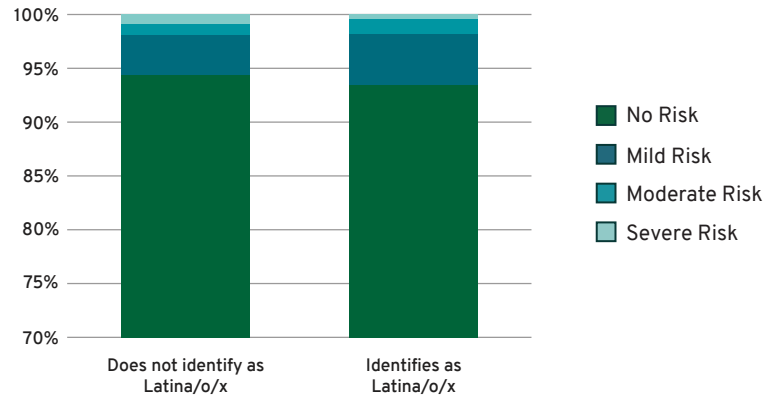


Alcohol Risk by Race



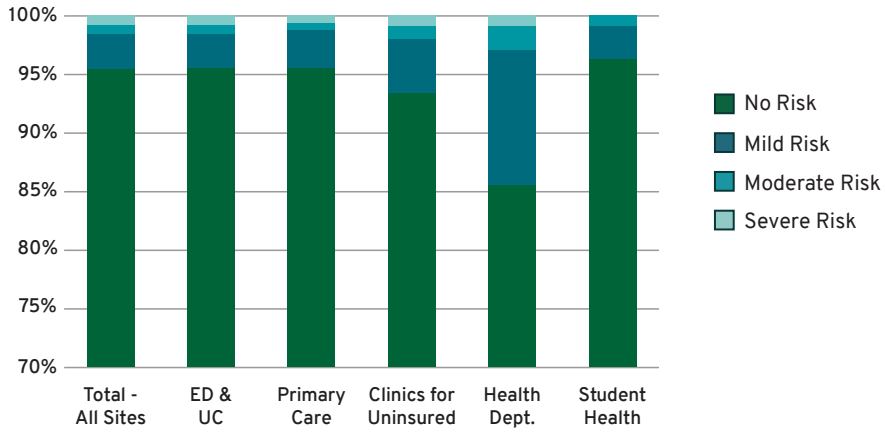
Note: The number of individuals who endorsed solely Native American or Native Hawaiian were small enough that in order to examine risk by identified race, they needed to be combined.

Alcohol Risk by Ethnicity



Alcohol, Cannabis, and Other Drug Use

Alcohol Use: By Site Type



The universal screen for alcohol use includes the first three questions of the US AUDIT or the US AUDIT-C. The first question of the US AUDIT-C is "In the past year, how often do you have a drink containing alcohol?" If an individual answers 'never', no further US AUDIT questions are asked. Below is a reflection of the number of individuals who endorsed ANY drinking by site type.

	Indication of Drinking ANY Alcohol by Site Type					
	Total Across All Sites	Emergency Dept. & Urgent Care	Primary Care Practice	Clinics for Uninsured	Health Dept.	Student Health Service
Any Alcohol Use	**29%**	**24%**	**42%**	**40%**	**74%**	**53%**

As part of the US AUDIT-C, individuals who endorse ANY alcohol use are asked the frequency with which they engage in binge drinking. Below is a chart that represents the frequency of binge drinking among those who use alcohol by site type.

While Virginia county health departments had the high percentage of individuals who reported any binge drinking and acute care settings the lowest, acute care settings had a significantly higher percentage of individuals who endorsed daily binge drinking.

	Frequency of Binge Drinking Across Site Type					
	Total Across All Sites	Emergency Dept. & Urgent Care	Primary Care Practice	Clinics for Uninsured	Health Dept.	Student Health Service
Never	**61%**	**70%**	**55%**	**54%**	**31%**	**43%**
< Monthly	**19%**	**9%**	**29%**	**24%**	**40%**	**37%**
Monthly	**7%**	**4%**	**8%**	**10%**	**17%**	**14%**
Weekly	**5%**	**4%**	**4%**	**5%**	**9%**	**5%**
2-3x per Week	**2%**	**2%**	**3%**	**2%**	**3%**	**1%**
4-6x per Week	**1%**	**1%**	**1%**	**1%**	**1%**	**0%**
Daily	**6%**	**8%**	**1%**	**4%**	**0%**	**0%**

Alcohol, Cannabis, and Other Drug Use

Cannabis Use

Cannabis use laws continue to change state by state as does individuals' perception of cannabis as an illicit drug. Thus, at the beginning of the Virginia SBIRT effort, the project team felt it important to uniquely identify and address cannabis apart from other drug use.

Thus, the following universal screening question for cannabis was included: *"In the past year, how often have you used marijuana?"* **Any use endorsed was considered positive for risk as for the majority of the grant period, recreational cannabis use in Virginia was considered illegal.**

While 7% of all adults screened used cannabis in the past year, rates of cannabis use varied by demographic factors and site type.

- Individuals who identified as transgender, nonbinary or other gender identities used cannabis at greater rates and greater frequency compared to males and females.
- Cannabis use rates and frequency also decreased as age increased.
- Individuals who identified as Asian or White reported lower rates of cannabis use overall compared to other groups.
- Regarding site type, rates of any cannabis use were 30% and 14% at the Health Department STI clinics and Student Health respectively.
- **Among cannabis users, 43% reported using 2 or more times per week.**

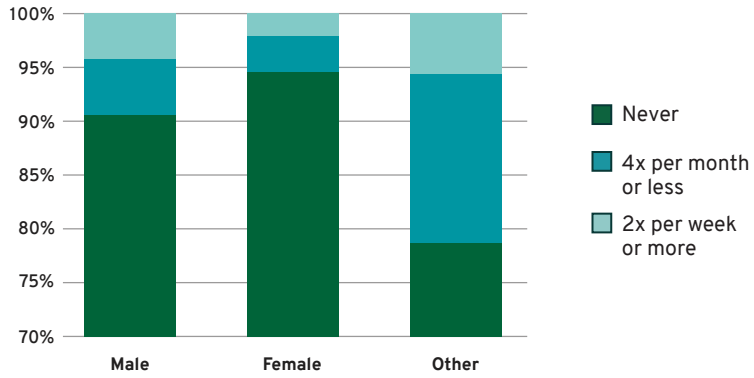
"I was not aware of the extent of the damage that could be done from marijuana…The conversation with [SBIRT clinician] was more practical and low key. The timing was really helpful. It put things into perspective and what was important to me."

SBIRT Participant

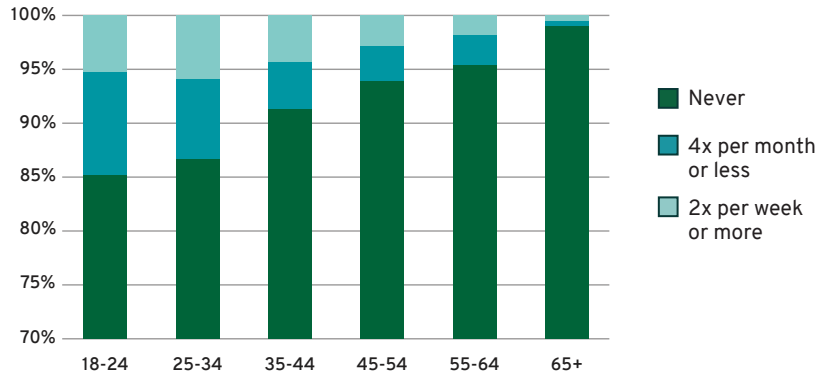
Alcohol, Cannabis, and Other Drug Use

Cannabis Use: Demographics

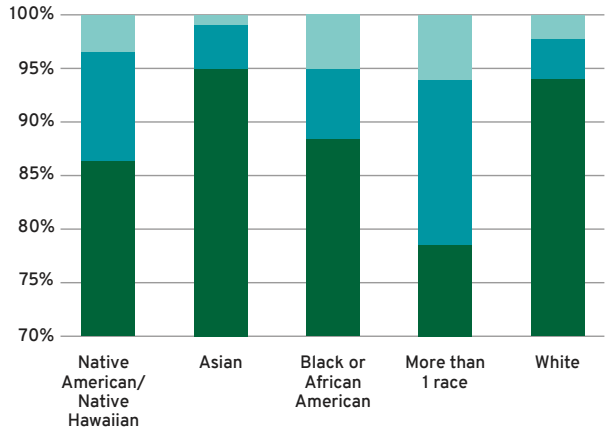
Cannabis Risk by Gender



Cannabis Risk by Age

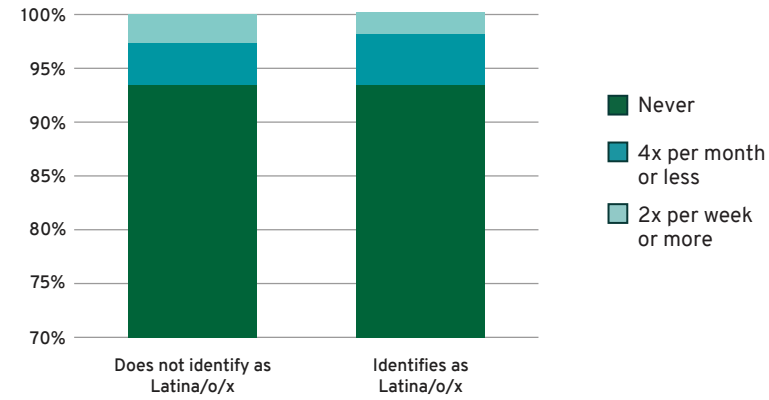


Cannabis Risk by Race



Note: The number of individuals who endorsed solely Native American or Native Hawaiian were small enough that in order to examine risk by identified race, they needed to be combined.

Cannabis Risk by Ethnicity



Alcohol, Cannabis, and Other Drug Use

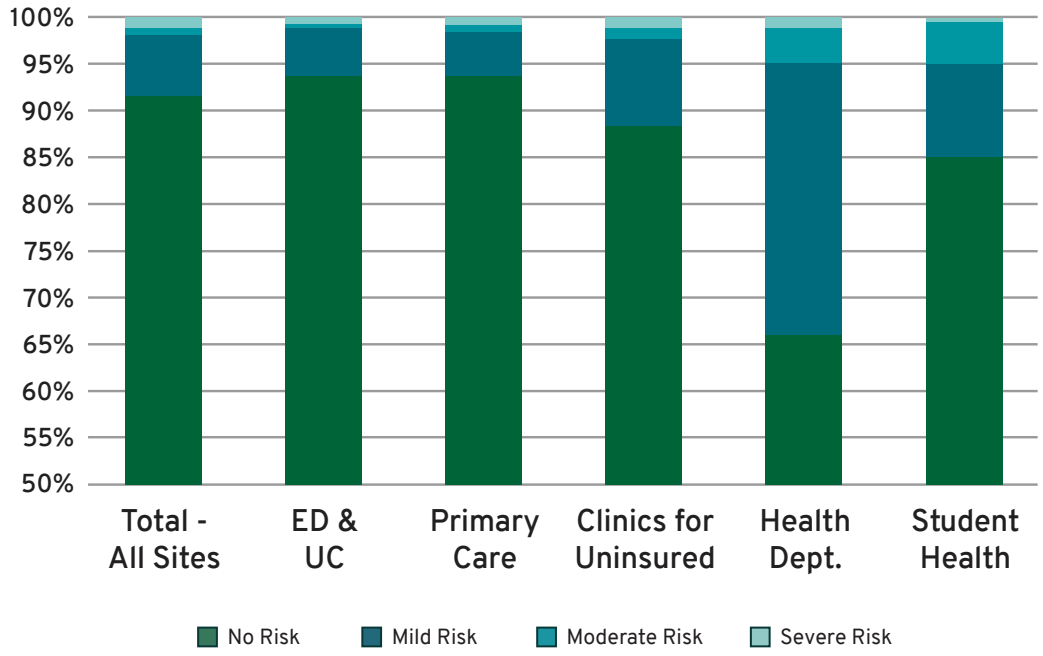
Other Drug Use

Individuals are asked about **prescription drug misuse and use of illegal drugs** over the past year. Overall, the percentages of individuals endorsing prescription drug misuse was 1.2% and use of illegal drugs was 1.4%. However, across the different site types, 9% and 7% of individuals screened at the Virginia county health department STI clinics endorsed prescription drug misuse and use of illegal drugs respectively. The range of percentages for other sites ranged from 0.8% to 1.7% for prescription drug misuse and 0.9% to 1.4% for illegal drug use.

Overall, 8% of individuals were positive for risky drug use which includes cannabis, prescription drug misuse and illegal drug use.

As shown in the figure to the right, a higher percentage of individuals screened at the Virginia county health department STI clinics (34%), student health center (15%) and clinics for the uninsured (12%) scored positive for risky drug use as measured by the DAST-10 compared to other sites.

Drug Risk by Medical Site Type



Individuals Positive for Risky Drug Use

Three out of every four individuals positive for risky drug use endorsed solely cannabis use (no prescription or illegal drug misuse).

Depression

As part of the initial screening process, outpatient, non-acute medical sites included the **Patient Health Questionnaire-9 items** (PHQ-9) in their universal (PHQ-2) and secondary (remaining seven items) screening process to ask about depressive symptoms. Similar to the US AUDIT and DAST-10, responses on the PHQ-9 are scored and stratified by risk level. Participating acute care centers elected to use existing mental health response teams to assess for mental health concerns. Thus, their data are excluded from the summary below.

Depression Observations

When considering depression risk by demographic factors, the following was observed:

- Males reported less depressive symptoms compared to other gender groups.
- Individuals who identified as transgender, nonbinary or other gender identities had more than twice the rates of depression risk compared to males and significantly more than females.
- Middle-aged adults reported experiencing greater depressive symptoms compared to youth, young adults and older adults.
- Individuals who identified as Asian endorsed fewer depressive symptoms compared to other groups.
- There were no differences in the prevalence of depressive symptoms by Latin American ethnicity.

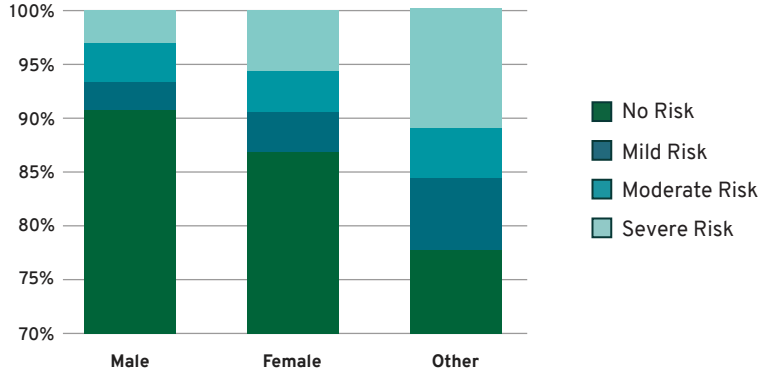
"I felt like it was an open environment where I could discuss things I had not really talked about with anyone before."

SBIRT Participant

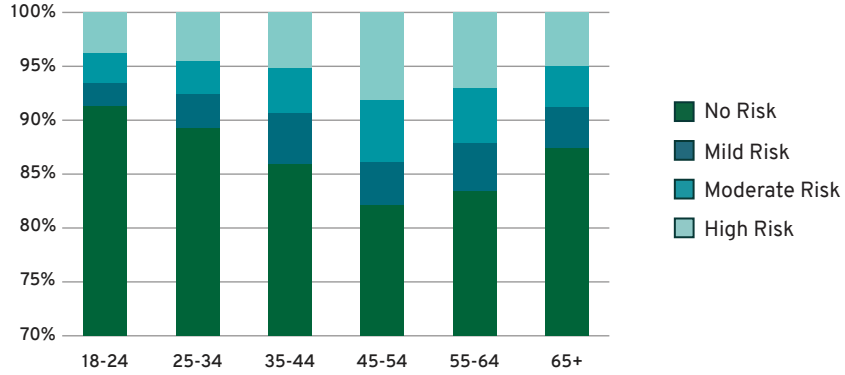
Depression

Depression: Demographics

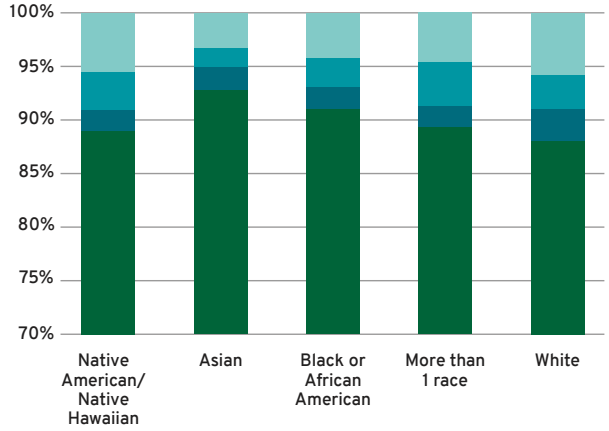
Depression Risk by Gender



Depression Risk by Age

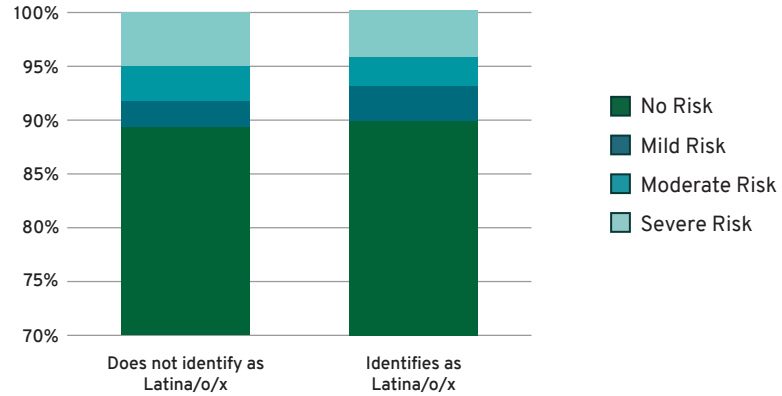


Depression Risk by Race



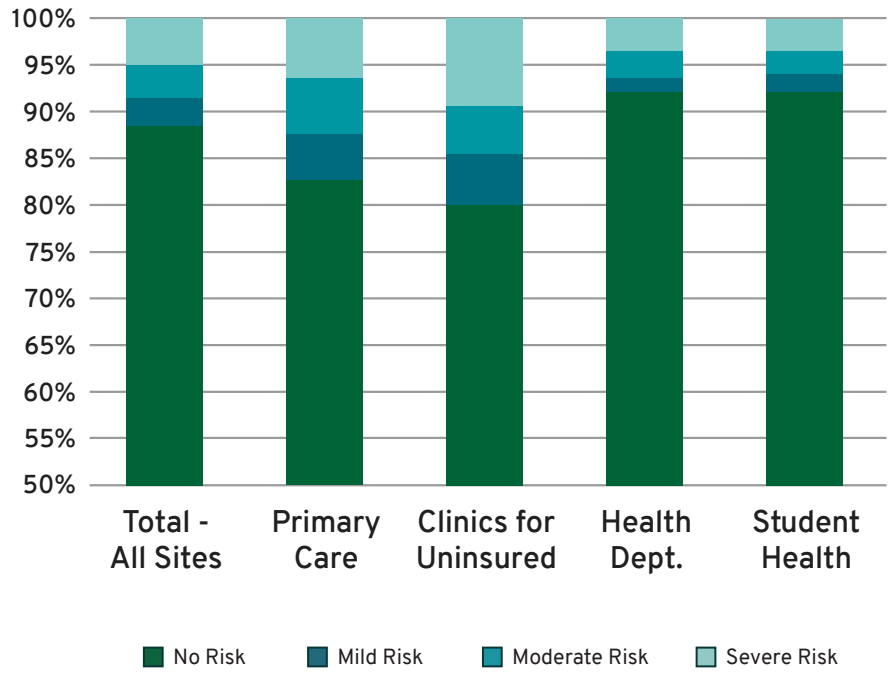
Note: The number of individuals who endorsed solely Native American or Native Hawaiian were small enough that in order to examine risk by identified race, they needed to be combined.

Depression Risk by Ethnicity

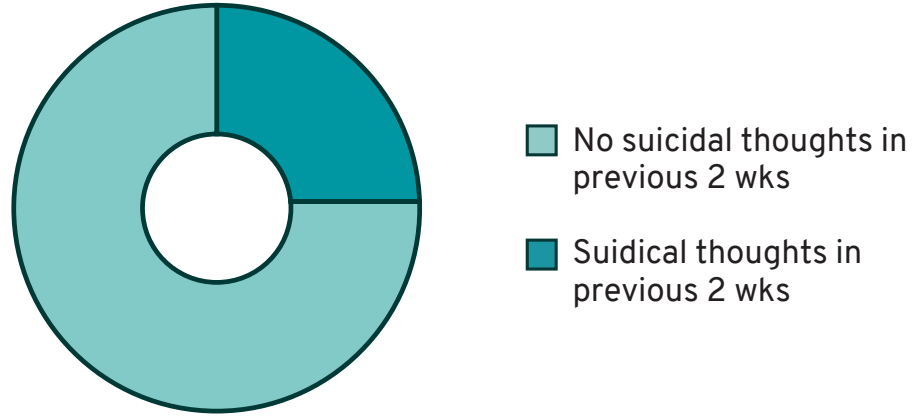


Depression

Depression Risk by Medical Site Type



Percent positive for suicidal thoughts among those who scored positive on PHQ-2 universal screen



The PHQ-9 asks about frequency of suicidal thoughts among those who score positive on the PHQ-2 universal screen. Of those in non-acute care settings who scored positive on the universal screen, **25% endorsed experiencing suicidal thoughts or thoughts of self-harm in the 2 weeks prior to screening.**

Intervention Delivery

Two critical steps are involved to arrive at the point where an individual might receive an intervention.

- First, when an individual scores positive for alcohol, cannabis, or other drug risk, depression risk, or tobacco risk on the **universal screen**, the SBIRT model indicates those individuals should receive a secondary, more comprehensive screen as described earlier.
- Second, once an individual receives a secondary screen, their responses are scored and stratified across the risk continuum for each given screening tool.

The individual's risk level then determines the type of intervention.

- For individuals who score low risk, a Brief Intervention (BI) or Behavioral Activation (BA) intervention is indicated. BI/BAs are conducted immediately after screening, explore aspects in the individual's life related to the identified risk, and provide educational information with the goal of increasing awareness and eliciting a commitment to change to reduce risk.
- For those at moderate risk, on site Brief Treatment (BT) is indicated which can typically include up to 12 outpatient therapy sessions.
- For those at severe risk, a referral to a substance abuse or mental health treatment center is indicated (RT).

All sites implemented SBIRT within their existing workflow and thus, the transition from the universal to secondary screen varied.

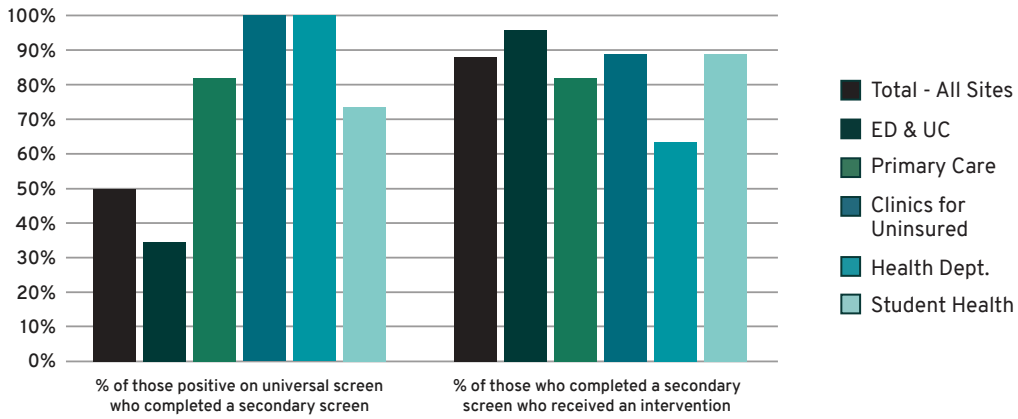
- Within the larger acute care settings, often the universal screen was conducted by nursing staff as part of the initial triage process. If an individual was positive, a request for a consult from the SBIRT clinical team was required to progress to the secondary screening and intervention delivery.
- For smaller, non-acute sites, often, the universal screen was conducted as part of the initial appointment registration or check in. Then, once the individual was brought to an exam room, the medical team, including the SBIRT clinician, would identify when the SBIRT clinician could meet with the individual to complete the secondary and if needed, intervention. Another alternative was that the universal screen unfolded immediately to the secondary screen so that both sets of screening questions were administered at the same timepoint in the visit.

Intervention Delivery

The chart below reflects this two-part process described.

- The first cluster of bars reflects the percentage of individuals who were positive on their universal screen and completed the secondary screening questions. Acute care settings experienced greater challenges successfully transitioning from the universal to the secondary screen. These challenges were due to a variety of reasons including lack of outreach to the SBIRT clinical team, medical needs of the patients being severe enough to prohibit a visit by the SBIRT clinical team, primary nature of concern was mental health related necessitating a call to the behavioral health unit, and patients discharged before they could be seen by the SBIRT clinical team.

Secondary Screen and Intervention Delivery Rates



- The second cluster of bars reflects the percentage of individuals who received a secondary screen who then went on to receive an intervention for their substance use. In general, intervention delivery rates were strong across all sites for individuals who had completed a secondary screen.

Moderate risk patients should receive Brief Treatment (BT) and severe risk patients should receive a Referral to Specialty Substance Abuse Treatment (RT). The charts on the following page show the change in acceptance rates as the intervention level increased.

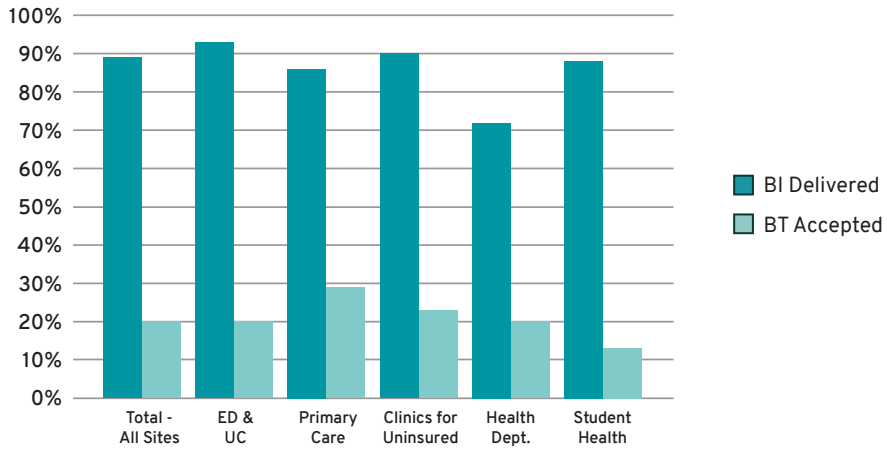
- In general, individuals with greater severity of alcohol and other drug risk were more likely to receive at least a BI compared to a higher level of care.

- **In addition, for those with severe risk, many accepted on site brief treatment as an alternative to an outside referral to treatment, highlighting the importance of on-site treatment availability in medical settings where SBIRT is provided.**

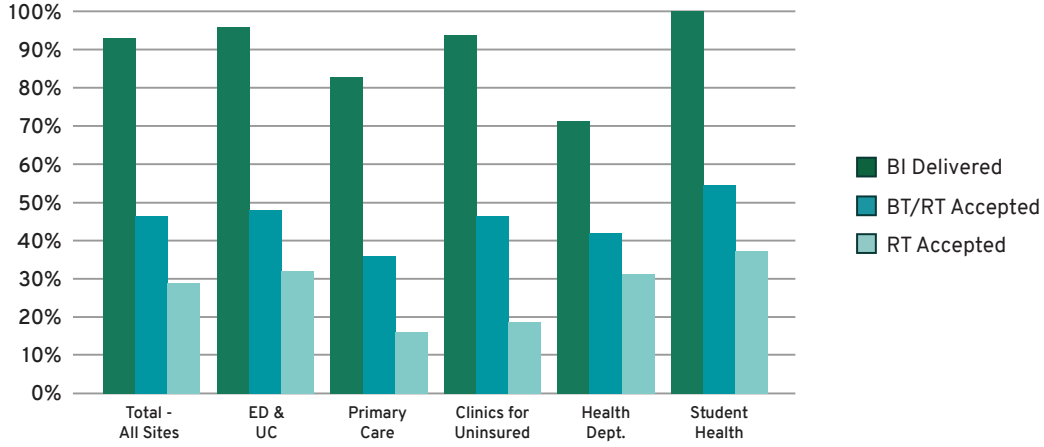
- Of note, a greater percentage of individuals at severe risk received a RT at ED & UC and student health centers compared to other medical sites.

Intervention Delivery

BI vs BT Acceptance Rate Among Moderate Risk Patients

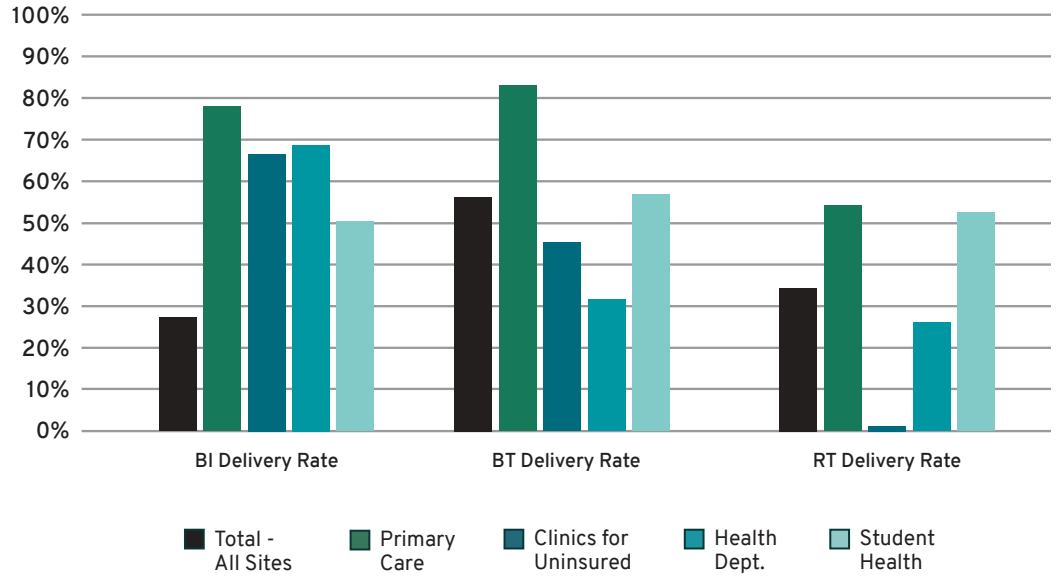


BI, BT vs RT Acceptance Rate Among Severe Risk Patients



Across all patients who screened positive for *DEPRESSIVE SYMPTOMS* and were not already engaged in treatment, 46% received an intervention. The percent jumps to 62% when you omit the Emergency Department and Urgent Care centers. As shown below, primary care centers demonstrated the highest level of intervention delivery across all levels of depression risk. 12% of patients with depressive symptoms were already engaged in treatment at the time of their screening.

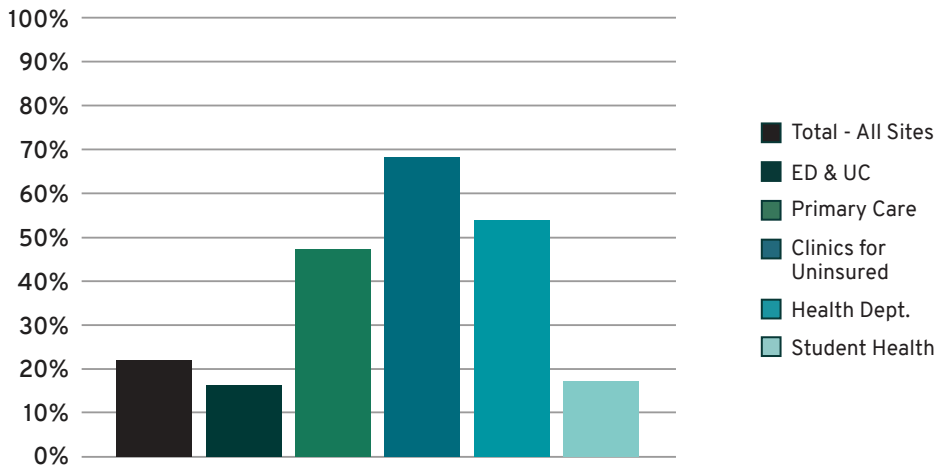
Depression Intervention Delivery Rate by Intervention Type/Risk Level Across Different Medical Sites



Intervention Delivery

Across all individuals who screened positive for ***TOBACCO***, 22% received an intervention. Intervention delivery rates for tobacco were higher at clinics for the uninsured followed by Virginia county health department STI clinics and primary care practices. The range of interventions included brief interventions, on site treatment including the use of nicotine cessation medication, and referrals to nicotine cessation services. Only 1% of patients who reported tobacco use were already engaged in treatment at the time of their screening.

Tobacco Use Intervention Delivery Rate



In summary, there were a total of 11,754 interventions delivered to the current sample of unique individuals. 4524 were for tobacco risk, 5205 were for alcohol or drug use risk, and 2025 were for depression risk.

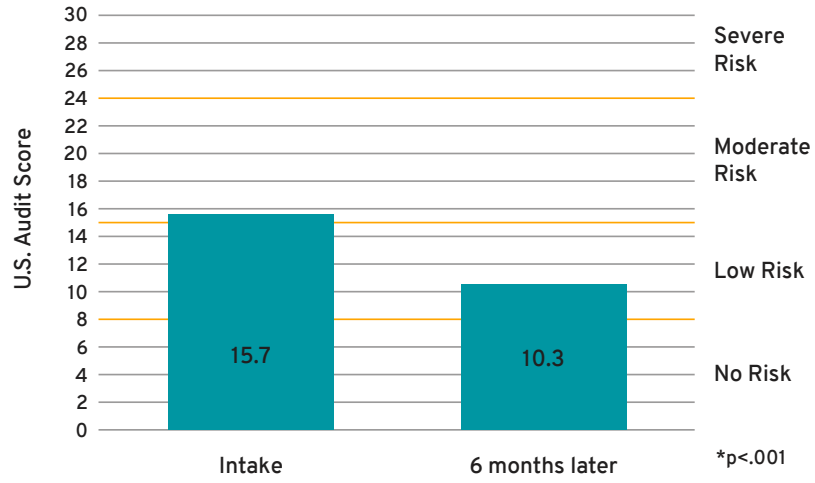
Patient Outcomes

Alcohol and Other Drug Use Outcomes

In order to measure the impact of SBIRT on individuals' substance use over time, there was an effort made on the part of all participating sites to recruit 10% of all patients with risky alcohol and/or drug use **AND** who received an intervention into the outcome evaluation. COVID significantly impacted follow up evaluation recruitment in addition to implementation, resulting in a total of 8% of eligible patients enrolled into the follow up evaluation. Those patients were interviewed 6 months after their initial screening and intervention and asked the same questions as the initial screen for the past 6 months. **A total of 311 patients completed the outcome evaluation.**

Outcome data in the figure to the right shows the average score at intake (score = 15.7) among those who scored positive and received an intervention for risky alcohol use. As shown, 6 months later, among those who took part in the follow up interviews, the average score had decreased significantly to 10.3. US AUDIT scores can range from 0 to 46.

Average US Audit Scores Decreased* (n=161)



One of every 2 (50%) individuals who received an intervention for risky alcohol use were either:

36%

within recommended drinking limits 6 month later, or

14%

had decreased their level of risk.

27%

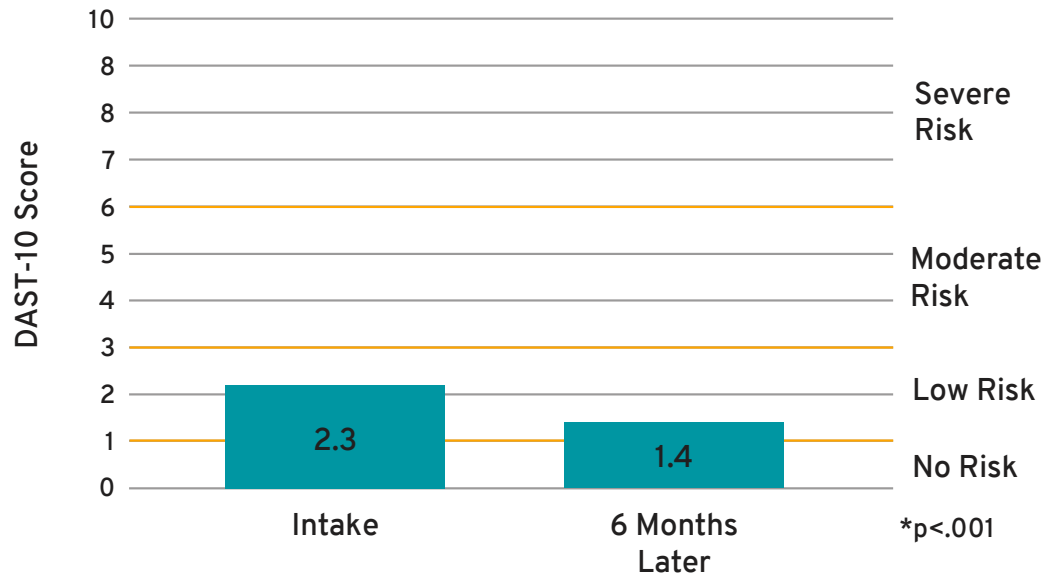
Over a quarter of the sample eliminated binge drinking.

Patient Outcomes

Alcohol and Other Drug Use Outcomes

Outcome data in the graph below show the average DAST-10 score at intake (score = 2.3) among those who scored positive for drug risk. As shown, 6 months later, among those who took part in the follow up interviews, the average score had decreased significantly to 1.4. Of note, DAST-10 scores can range from 0 to 10.

Average DAST-10 Scores Decreased Slightly* (n=205)



Two of every 5 (39%) individuals who received an intervention for risky drug use were either:

32%

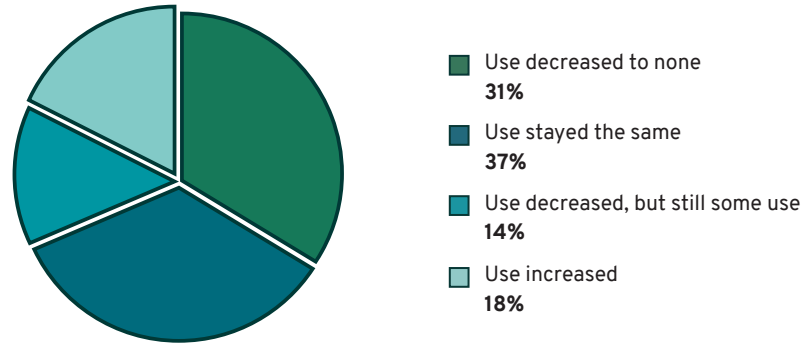
abstinent 6 months later, or

7%

had decreased their level of risk

74% of individuals positive for drug risk endorsed using solely cannabis. Importantly, among those who used cannabis, 31% had become abstinent 6 months later while another 14% had decreased their cannabis use.

Change in Frequency of Cannabis use Over Time Among Cannabis Users at Intake (N=179)

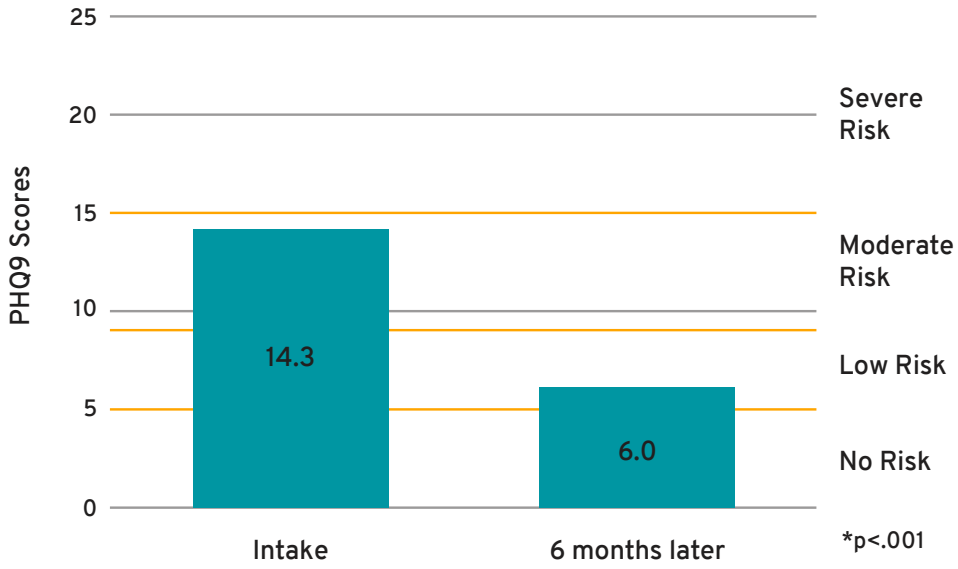


Patient Outcomes

Mental Health Outcomes

The primary focus of SBIRT is to identify risky alcohol and drug use and provide interventions whose intensity are matched to the level of risk. At the same time, there is a growing understanding of the need to simultaneously identify and address mental health risk. As part of Virginia's SBIRT effort, individuals are routinely screened for depression. However, for the 6 month follow up evaluation, the focus remains on those who primarily received an intervention for risky alcohol and/or drug use. Thus, outcome data on depression are limited and the sample size is very small.

Average PHQ Scores Decreased Significantly* (n=31)



Seven of every ten (71%) individuals who received an intervention for depression were either:

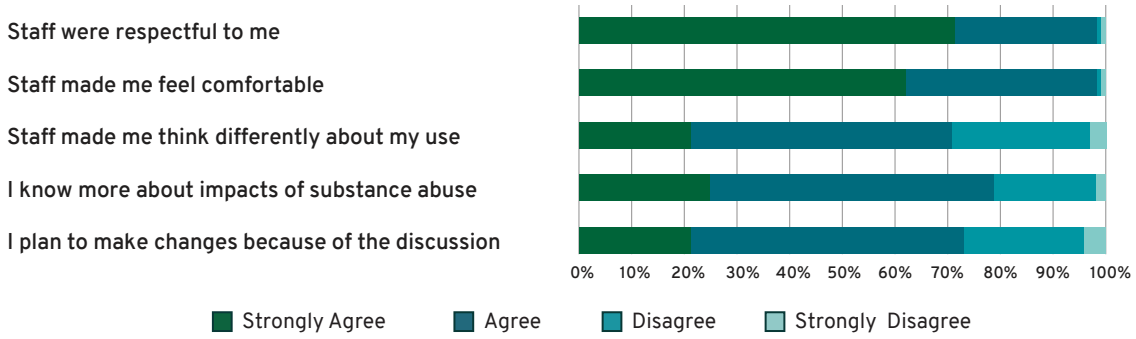
at no risk, or

had decreased their level of risk

Patient Satisfaction

One noted barrier to implementing SBIRT is concern on the part of providers that asking patients about their alcohol and other drug use is invasive and not the primary reason for their patients' visits to the medical site. Participants of the follow up evaluation were asked if they recalled their initial screening and related intervention. Those who endorsed recalling the discussion (n=241 or 79% of follow up participants) were asked a series of patient satisfaction items. Patients overwhelmingly endorsed feeling comfortable discussing their use and felt staff were respectful. **In addition, 3 out of every 4 individuals (73%) indicated they found the SBIRT related discussion very helpful or helpful.**

Patient Satisfaction With SBIRT Services



"Appreciated the facts given and the fact that [SBIRT clinician] was very non-judgmental and down to Earth."

SBIRT Participant

CONCLUSIONS

Results

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an important secondary prevention strategy to address substance use and depression risk.

- Between 2016-2021, the Virginia SBIRT Project supported the integration of SBIRT into 13 medical settings and 6 mental health agencies.
- This collaborative effort led to the screening of 104,391 Virginians, resulting in opportunities to provide interventions to 11,754 people with substance use and/or depression risk.

Moreover, these interventions helped to change individual trajectories of substance use and depression.

- Based on a random 10% sample of people receiving services, SBIRT interventions effectively decreased alcohol and illicit drug use and depression.

One of every 2 (50%) individuals who received an intervention for risky alcohol use were either within recommended drinking limits 6 month later (36%) or had decreased their level of risk (14%). In addition, 27% had eliminated binge drinking.

Two of every 5 (39%) individuals who received an intervention for risky drug use were either abstinent 6 months later (32%) or had decreased their level of risk (7%).

Seven of every ten (71%) individuals who received an intervention for depression were either at no risk (55%) or had decreased their level of risk (16%).

The Virginia SBIRT project demonstrated that SBIRT does work and that people are comfortable with SBIRT services. Individuals receiving interventions overwhelmingly endorsed feeling comfortable discussing their use and felt staff were respectful toward them.

3 out of every 4 individuals (73%) indicated they found the SBIRT related discussions very helpful or helpful.

CONCLUSIONS

Results

It is the hope of the project team that by sharing our approach to implementing SBIRT and the outcomes of this work, that others will consider SBIRT as a powerful strategy to enhance and expand substance use prevention nets in their communities.

For Implementers:

- SBIRT as a public health strategy is appealing in its capacity for flexible adaptation to fit unique target populations and settings. We encourage those considering SBIRT implementation to review the wealth of resources available through Substance Abuse and Mental Health Services Administration (SAMHSA) and other agencies (e.g., Addiction Technology Transfer Center Network, Centers for Medicaid and Medicare Services). Resources include implementation guides, guidance on facilitating the organizational change process, foundational knowledge and interactive clinical skills trainings, clinical tools to support provider service delivery, patient education materials to enhance awareness raising, and documentation and reimbursement guides.

For Policymakers:

- Early intervention for substance use is recommended by a number of federal agencies, including the U.S. Preventative Services Task Force national guidelines. Continued and expanded funding for SBIRT within a variety of sectors is important. Federal, state, and local support of implementation of SBIRT is critical to addressing substance misuse and depression in the nation.

We appreciate you taking the time to learn more about the Virginia SBIRT Project. If you have any questions or would like to learn more, please email us at adapt@wb.hidta.org.

Should SBIRT be involved in your future work, we wish you great enjoyment and success on your journey.

Together we can change lives, one screen at a time!

APPENDIX

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APPENDIX

Appendix 1

VA-SBIRT Practice Needs Assessment

Agency Name: _____

Your Name: _____

How often are patients screened for substance use?
- ❍ Not at all
- ❍ Rarely
- ❍ Sometimes
- ❍ Often
- ❍ Always (i.e., universal routine screening)

If so, what screen(s) is used?

_____

How often are patients screened for behavioral health conditions?
- ❍ Not at all
- ❍ Rarely
- ❍ Sometimes
- ❍ Often
- ❍ Always (i.e., universal routine screening)

If so, what screen(s) is used?

_____

Who administers the screen?
- ❍ Nurse
- ❍ MD
- ❍ MA
- ❍ other (please specify) _____

Who interprets the screen?
- ❍ Nurse
- ❍ MD
- ❍ MD
- ❍ Other (please specify) _____

VA-SBIRT Practice Needs Assessment

Is feedback on screening shared with patients during the same visit?
- ❍ Never
- ❍ Rarely
- ❍ Sometimes
- ❍ Often
- ❍ Always

How often do you use patient substance use and /or behavioral health data to measure and evaluate outcomes?
- ❍ Never
- ❍ Rarely
- ❍ Sometimes
- ❍ Often
- ❍ Always

Please rate the following:

	Not at All		Some Protocols in Place		Consistently used
	1	2	3	4	5
To what extent are protocols in place for conducting evidence-based interventions (e.g. Motivational interviewing) for patients with risky substance use?	❍	❍	❍	❍	❍

	Not at all		Some receive referrals		All pts receive referrals
	1	2	3	4	5
To what extent are protocols in place for patients to be referred to specialty substance abuse treatment facilities?	❍	❍	❍	❍	❍

	Not at all		Some are collaborative		All are collaborative
	1	2	3	4	5
To what extent are referrals to specialty clinics for substance use performed collaboratively (e.g., work with patient to make the appointment prior to leaving your clinic and identifying solutions to follow-through barriers)	❍	❍	❍	❍	❍

APPENDIX

Appendix 1

VA-SBIRT Practice Needs Assessment

Please rate the following:

Not at all — Tools for some areas — Tools and materials for all types

	1	2	3	4	5
To what extent are educational tools and patient materials readily available to providers when discussing risky substance use?	❍	❍	❍	❍	❍

\Are medical records paper or electronic?

❍ Paper
❍ Electronic

If you use an EHR, which EHR is used?

_____

Are screening tools integrated into the EHR?

❍ Yes
❍ No

Are screening results integrated into the EHR?

❍ Yes
❍ No

Are interventions or follow up of screening results integrated into the EHR?

❍ Yes
❍ No

What is the name and contact info for the person responsible for EHR management?

_____

Please check your perceived level of behavioral health integration:

❍ Integrated- Close/Full Collaboration (same building, shared treatment plan)
❍ Co-Located - Basic/Close Collaboration Onsite (same building, some collaboration)
❍ Coordinated - Minimal/Basic Collaboration (different location/agency)
❍ None
❍ Other (please specify below) _____

VA-SBIRT Practice Needs Assessment

Please indicate your level of satisfaction:

	Not at all	Slightly	Moderately	Very	Extremely
How satisfied are you with the behavioral health integration at your agency?	❍	❍	❍	❍	❍

Please rate the following question:

Not at all — Some — Many

	1	2	3	4	5
Do you have any linkages (e.g., MOU's, service agreements, common release of information) in place with community-based specialty treatment providers?	❍	❍	❍	❍	❍

How satisfied are you with these linkages?

❍ Not at all
❍ Slightly
❍ Moderately
❍ Very
❍ Extremely

What challenges do you see in SBIRT integration? (check all that apply)

❑ Limited visit time for education/counseling
❑ Limited training to adequately address substance use problems in current setting
❑ Lack of clinical tools to support provider implementation
❑ Lack of educational patient materials to facilitate education/counseling
❑ Limited perceived efficacy to adequately address substance use problems
❑ Low perceived utility by providers
❑ Lack of availability of addiction treatment resources (too hard to access or not available)
❑ Lack of reimbursement from insurers or commercial payers
❑ Other (please specify) _____

APPENDIX

Appendix 2

Screening

Screening is broken down into two levels: universal screening and secondary screening. Universal screening is the process of screening all patients for a particular condition. By screening all people, we can normalize and de-stigmatize discussions about substance use and catch the approximately 90 percent of substance use disorders that go unrecognized and untreated.

Because we know that approximately 75% of the adult population will have a negative screening score indicating low/no risk, it is advantageous to provide a simple universal screen. Once those individuals with low/no risk are ruled out, the focus can shift to the remaining 25% who are likely at risk for a psychosocial or health care problem related to their substance use choices.

Mason SBIRT recommends the following universal and secondary screening tools.

	Universal Screen	Secondary Screen
Alcohol	USAUDIT-C	USAUDIT
Tobacco	Single item assessing tobacco use	No Secondary Screen is given
Drugs	Four items assessing drug use	DAST-10
Depression	PHQ-2	PHQ-9

Note: In the cases of alcohol, drugs, and depression, results of the universal screen are populated into the secondary screening questions so that redundant items are not asked twice. The scoring guide below provides direction on how to score these instruments.

Sample Screening Intro Script:

Before you see your provider, we have a few questions we would like you to answer regarding behaviors that could affect your health and wellness. Because we care about your health, we are asking all of our patients these questions on a routine basis and someone from your healthcare team will discuss your results with you during your visit. Your answers will become part of your medical record and therefore is protected the same way as the rest of your medical information.

VA-SBIRT Screening Instrument Library

Universal Screening Options

Alcohol Universal Screen (USAUDIT-C)	Scoring system						
	0	1	2	3	4	5	6
Think about your drinking in the past year. A drink means one 12oz beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.							
1. How often do you have a drink containing alcohol? **(If 'never' skip next two questions)**	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-8 drinks	10 or more drinks
3. How often do you have X - **Men 65 and younger**: 5 or more drinks on one occasion? - **Men age 66+**: 4 or more drinks on one occasion? - **Women (all ages)**: 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily

Tobacco Universal Screen	Scoring system				
	0	1	2	3	4
1. In the past month, how often have you used tobacco or any nicotine products (including cigarettes, e-cigarettes, juul, chewing tobacco, spliffs, moles, etc.)?	Never	1-2 times per month	Weekly	Almost daily	Daily

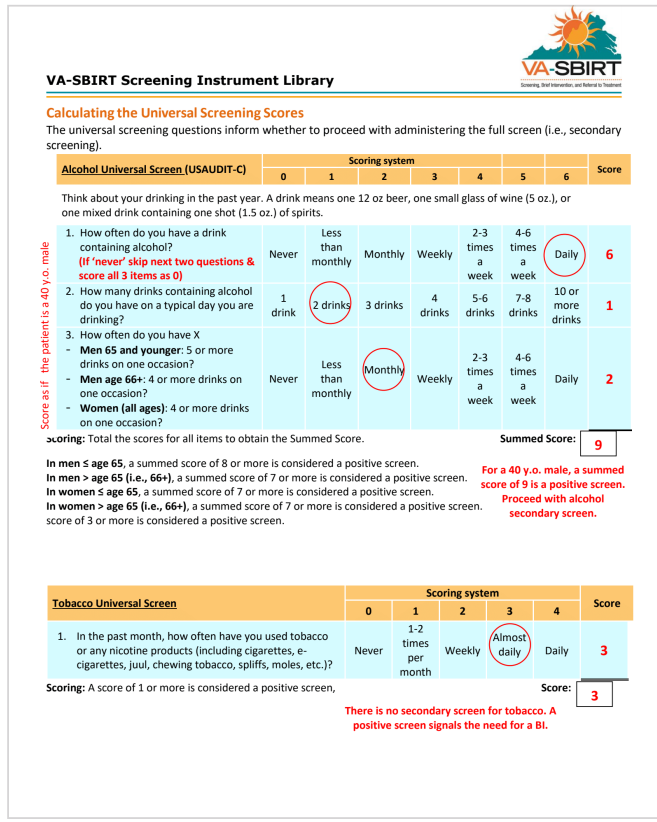
VA-SBIRT Screening Instrument Library

Drugs Universal Screen	Scoring system				
	0	1	2	3	4
1. How often have you used marijuana/cannabis in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
2. How often have you used prescription medications that were not prescribed to you in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
3. How often have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
4. How often have you used other drugs in the past year (for example, cocaine, street heroin, speed, club drugs, etc.)?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week

Depression Universal Screen (PHQ-2)	Scoring system			
	0	1	2	3
Over the past 2 weeks, how often have you been bothered by any of the following problems:				
1. Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly everyday
2. Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly everyday

APPENDIX

Appendix 2



VA-SBIRT Screening Instrument Library

Calculating the Universal Screening Scores

The universal screening questions inform whether to proceed with administering the full screen (i.e., secondary screening).

Alcohol Universal Screen (USAUDIT-C)	Scoring system 0	1	2	3	4	5	6	Score
Think about your drinking in the past year. A drink means one 12 oz beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.								
1. How often do you have a drink containing alcohol? **(If 'never' skip next two questions & score all 3 items as 0)**	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	6
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-8 drinks	10 or more drinks	1
3. How often do you have X - **Men 65 and younger**: 5 or more drinks on one occasion? - **Men age 66+**: 4 or more drinks on one occasion? - **Women (all ages)**: 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	2

Score as if the patient is a 40 y.o. male

Scoring: Total the scores for all items to obtain the Summed Score. **Summed Score:** 9

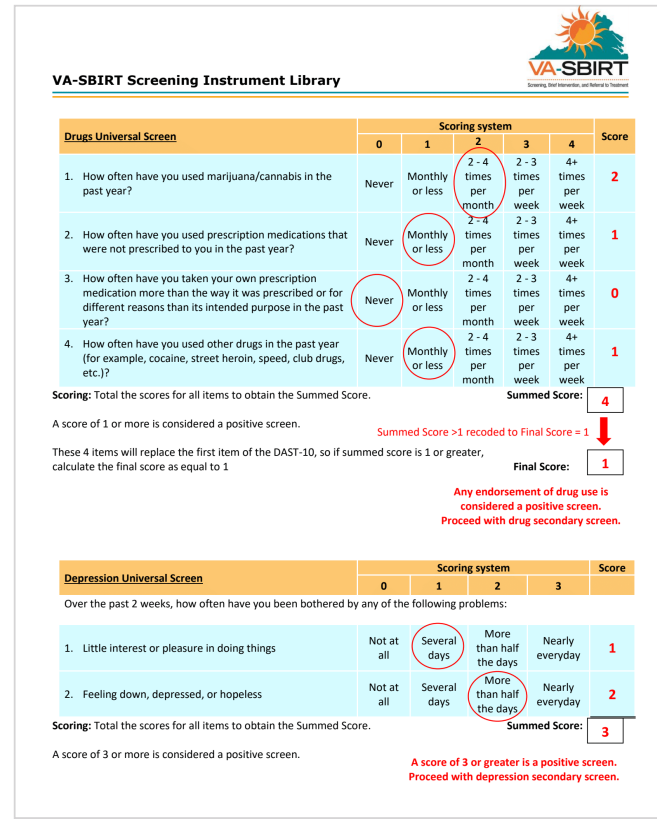
In men ≤ age 65, a summed score of 8 or more is considered a positive screen.
In men > age 65 (i.e., 66+), a summed score of 7 or more is considered a positive screen.
In women ≤ age 65, a summed score of 7 or more is considered a positive screen.
In women > age 65 (i.e., 66+), a summed score of 7 or more is considered a positive screen.
score of 3 or more is considered a positive screen.

For a 40 y.o. male, a summed score of 9 is a positive screen. Proceed with alcohol secondary screen.

Tobacco Universal Screen	Scoring system 0	1	2	3	4	Score
1. In the past month, how often have you used tobacco or any nicotine products (including cigarettes, e-cigarettes, juul, chewing tobacco, spliffs, moles, etc.)?	Never	1-2 times per month	Weekly	Almost daily	Daily	3

Scoring: A score of 1 or more is considered a positive screen, **Score:** 3

There is no secondary screen for tobacco. A positive screen signals the need for a BI.



VA-SBIRT Screening Instrument Library

Drugs Universal Screen	Scoring system 0	1	2	3	4	Score
1. How often have you used marijuana/cannabis in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	2
2. How often have you used prescription medications that were not prescribed to you in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	1
3. How often have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose in the past year?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	0
4. How often have you used other drugs in the past year (for example, cocaine, street heroin, speed, club drugs, etc.)?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	1

Scoring: Total the scores for all items to obtain the Summed Score. **Summed Score:** 4

A score of 1 or more is considered a positive screen.

Summed Score >1 recoded to Final Score = 1

These 4 items will replace the first item of the DAST-10, so if summed score is 1 or greater, calculate the final score as equal to 1 **Final Score:** 1

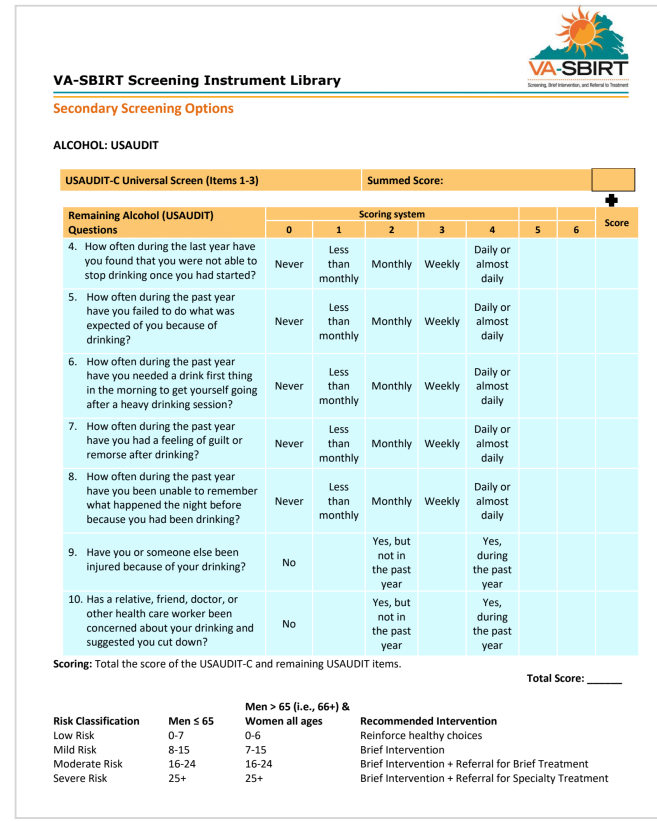
Any endorsement of drug use is considered a positive screen. Proceed with drug secondary screen.

Depression Universal Screen	Scoring system 0	1	2	3	Score
Over the past 2 weeks, how often have you been bothered by any of the following problems:					
1. Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly everyday	1
2. Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly everyday	2

Scoring: Total the scores for all items to obtain the Summed Score. **Summed Score:** 3

A score of 3 or more is considered a positive screen.

A score of 3 or greater is a positive screen. Proceed with depression secondary screen.



VA-SBIRT Screening Instrument Library

Secondary Screening Options

ALCOHOL: USAUDIT

USAUDIT-C Universal Screen (Items 1-3)	Summed Score:	✚

Remaining Alcohol (USAUDIT) Questions	Scoring system 0	1	2	3	4	5	6	Score
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 past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
6. How often during the past year have you needed a drink first thing 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 past 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 past 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 because of your drinking?	No		Yes, but not in the past year		Yes, during the past year			
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year			

Scoring: Total the score of the USAUDIT-C and remaining USAUDIT items.

Total Score: _____

Risk Classification	Men ≤ 65	Men > 65 (i.e., 66+) & Women all ages	Recommended Intervention
Low Risk	0-7	0-6	Reinforce healthy choices
Mild Risk	8-15	7-15	Brief Intervention
Moderate Risk	16-24	16-24	Brief Intervention + Referral for Brief Treatment
Severe Risk	25+	25+	Brief Intervention + Referral for Specialty Treatment

APPENDIX

Appendix 2

VA-SBIRT Screening Instrument Library

DRUGS: DAST-10

Drugs Universal Screen (4 items)	Final Score:	

**Note: Final score should either be a 0 or 1

Remaining Drugs (DAST) questions	Scoring system		Score
	No	Yes	
2. Do you use more than one drug at a time?	0	1	
3. Are you always able to stop using drugs when you want to?	1	0	
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1	
5. Do you ever feel bad or guilty about your drug use?	0	1	
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1	
7. Have you neglected your family because of your use of drugs?	0	1	
8. Have you engaged in illegal activities in order to obtain drugs?	0	1	
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1	
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1	

Scoring: Total the score of the Drugs Universal Screen final score and the remaining DAST items.

Total Score: _____

Risk Classification		Recommended Intervention
0	No Risk	Reinforce healthy choices
1-2	Mild Risk	Brief Intervention
3-5	Moderate Risk	Brief Intervention + Referral for Brief Treatment
6+	Severe Risk	Brief Intervention + Referral for Specialty Treatment

VA-SBIRT Screening Instrument Library

DEPRESSION: PHQ-9

PHQ-2 Universal Screen (Items 1-2)	Summed Score:	

Remaining Depression (PHQ-9) Items	Scoring system				Score
	0	1	2	3	
Over the past 2 weeks, how often have you been bothered by any of the following problems:					
3. Trouble falling asleep, staying asleep, or sleeping too much	Not at all	Several days	More than half the days	Nearly everyday	
4. Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly everyday	
5. Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly everyday	
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	Not at all	Several days	More than half the days	Nearly everyday	
7. Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	Several days	More than half the days	Nearly everyday	
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	Not at all	Several days	More than half the days	Nearly everyday	
9. Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly everyday	

Scoring: Total the score of the PHQ-2 and remaining PHQ-9 items.

Total Score: _____

If you checked off any problems, how difficult have those 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

Risk Classification		Recommended Intervention
0-4	No/Minimal Risk	None
5-9	Mild Risk	Watchful waiting, repeat PHQ-9 at follow-up visit
10-14	Moderate Risk	Treatment plan, consider counseling, follow-up and/or pharmacotherapy
15-19	Moderately/Severe Risk	Active treatment with pharmacotherapy or psychotherapy
20-27	Severe Risk	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

VA-SBIRT Screening Instrument Library

Full Screens

Alcohol Screening: USAUDIT

	Scoring system						
	0	1	2	3	4	5	6
Think about your drinking in the past year. A drink means one 12oz beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.							
1. How often do you have a drink containing alcohol? **(If 'never' skip remaining items)**	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-8 drinks	10 or more drinks
3. How often do you have X - **Men < age 65**: 5 or more drinks on one occasion? - **Men ≥ age 65**: 4 or more drinks on one occasion? - **Women (all ages)**: 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	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 past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
6. How often during the past year have you needed a drink first thing 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 past 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 past 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 because of your drinking?	No		Yes, but not in the past year		Yes, during the past year		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year		

APPENDIX

Appendix 2

VA-SBIRT Screening Instrument Library

Drug Screening: DAST-10

The following questions concern information about your possible involvement with drugs (not including alcoholic beverages) during the past 12 months. "Use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions/prescription, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

	Scoring system	
	No	**Yes**
In the past 12 months…		
1. Have you used drugs other than those required for medical reasons?		
2. Do you use more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to?	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use?	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

VA-SBIRT Screening Instrument Library

Depression Screening: PHQ-9

Depression Universal Screen	Scoring system			
	0	**1**	**2**	**3**
Over the past 2 weeks, how often have you been bothered by any of the following problems:				
1. Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly everyday
2. Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly everyday
3. Trouble falling asleep, staying asleep, or sleeping too much	Not at all	Several days	More than half the days	Nearly everyday
4. Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly everyday
5. Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly everyday
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	Not at all	Several days	More than half the days	Nearly everyday
7. Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	Several days	More than half the days	Nearly everyday
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	Not at all	Several days	More than half the days	Nearly everyday
9. Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly everyday
			Total:	

If you checked off any problems, how difficult have those 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

Appendix 3

Brief Negotiated Interview for Alcohol & Drug Use

The Brief Negotiated Interview (BNI) is a semi-structured motivational and awareness-raising discussion used in medical settings to generate behavior change plans with patients in a brief amount of time. The BNI is based on principles of motivational interviewing which includes exploring health behavior change with patients in a respectful, non-judgmental way while eliciting reasons for change and action steps from the patient. This gives the patient voice and choice, making any potential behavior changes more empowering to the patient. The BNI is intended to be brief, typically lasting five to fifteen minutes.

There are four basic steps of the BNI which are depicted in the BNI Guide Below.

1.Raise the subject	*If it's okay with you, let's take a minute to talk about the screening questions you answered today.* - *You mentioned that you use alcohol/drugs [X] amount. Tell me more about your use of [X]. When did you begin using? What is your use like now?*
Pros & Cons	*I'm interested in getting to know more about what [drinking/using] is like for you. Help me understand (what you enjoy/the good things) about [X]. What are some of the negatives?* - *So on the one hand [PROS-the good things about using] and on the other hand [CONS-the not so good things about using].*
Low Risk praise	*I see from your questionnaire that you have used [X] during the past 12 months and your amount of use falls into what we call a low-risk level. That's great. That's a healthy choice. It means your risk for preventable injuries and illnesses related to [X] is low.*
2.Provide Feedback	*I'd like to share some information on guidelines for [drinking and/or drug use] if that's alright.* *We know that…* • *Drinking 4 or more (Women) / 5 or more (Men) drinks in a few hours,* • *Drinking more than 7 (Women) / 14 (Men) drinks in a week, and/or* • *Using illicit drugs of any kind* *…can put you at risk for social or legal problems, as well as illness and injury. It can also cause health problems like [insert medical information] and can interfere with* [client's personal goals].
Elicit	*What do you think about that?*
3.Readiness ruler (1-10)	*Given what we have been discussing, help me understand how you feel about making a change.* - *On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to change some aspect of your [X] use?*
Reinforce positives	*[X] %. That's great. That means you're [X}% ready to make a change!*
If >1:	*Why did you choose that number and not a lower number like a 1 or 2?*
If = 1:	*What would it take to raise that number to say a 2 or 3?* - *How would your [X use] need to impact your life in order for you to start thinking about making a change?*
4.Negotiate a Plan Options if client cannot identify goal	*What steps can you take to (cut back use/reduce risk/stay healthy-safe)?* - *It seems you have several options. You can agree to stop using alcohol and/or drugs, you can cut your use down, you can go for some additional treatment, or you can do nothing.*
Identify supports	*What supports do you have for making this change? Tell me about a challenge you overcame in the past. How can you use those supports/resources to help you now?*
Explore confidence	*How confident are you that you can make a change? What would make you more confident?*
Have client write down action plan	*These are great ideas! Let's write down your Action Plan?* *This is what I heard you say….Is that accurate? Is there anything I missed or you want to add?*
Offer appropriate resources	*I have some resources that people sometimes find helpful. Would you like to hear about them?* • *Mental health/substance treatment, handouts/information, primary care, AA/NA*
Close	*Thank you for taking time to discuss this with me and being so open.*

It is helpful for providers to determine how they, in their own words, might approach the BNI. In the 'Script Development' space below, write a script that best fits you and a typical situation.

SCRIPT DEVELOPMENT

1.Raise the subject **Pros & Cons** Low Risk praise	
2.Provide Feedback Elicit	
3.Readiness ruler (1-10) Reinforce positives If >1: If = 1:	
4.Negotiate a Plan Options if client cannot identify goal Identify supports Explore confidence Have client write down action plan Offer appropriate resources	
Close	

BNI for Tobacco

1.Ask **Raise the subject**	*If it's okay with you, let's take a minute to talk about the screening questions you answered today.* *You mentioned that you use [tobacco/e-cigarettes]. Tell me more about your use of [X].* *[If tobacco status not assessed, ask "Do you currently smoke or use other forms of tobacco or e-cigarettes?]*
Pros & Cons	*Help me understand the good things about using tobacco. What are some of the negatives?* - *So on the one hand [PROS-the good things about using] and on the other hand [CONS-the not so good things about using].*
2.Advise	*I'd like to share some information on tobacco use if that's alright.* *I'm sure you know that tobacco use causes health problems, but I just want to make sure you know that tobacco use has also been linked to health problems you've been experiencing like [insert patient condition(s) for which tobacco/smoking is a risk factor].* *Quitting tobacco/smoking is one of the best things you can do for your health. And there are a lot of resources that can help.*
Elicit	*What do you think about that?*
3.Assess **Readiness ruler (1-10)**	*On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to quit tobacco use/smoking?*
Reinforce positives	*[X] %. That's great. That means you're [X}% ready to make a change!*
If >1:	*Why did you choose that number and not a lower number like a 1 or 2?*
If = 1:	*What would it take to raise that number to say a 2 or 3?*
4.Assist **Negotiate a Plan**	*Are you interested in quitting tobacco/smoking at this time?*
If NOT ready	*Sounds like you're not ready to quit tobacco/smoking just yet, but you have some interest in quitting in that you [repeat reason given for choosing X number instead of a 1 or 2]. What are some steps you can take to get yourself closer to being ready to quit?* *[Let them know you are ready to help them when they are ready to quit.]*
If ready	*[Provide brief counseling and cessation medication if appropriate.]*
Offer resources	*Virginia has some great resources that can increase your chance of quitting for good. Would you like to hear about them?* *[Encourage patient to visit Quit Now Virginia (https://www.quitnow.net/virginia/) or the National SmokeFree program (https://www.smokefree.gov/) to learn more about all the resources and to sign up to quit online. Provide informational handouts.]*
Arrange	*Follow up regularly with patients who are trying to quit.*

APPENDIX

Appendix 4

SAMHSA Behavioral Health Treatment Services Locator:
findtreatment.samhsa.gov

VA-SBIRT
Screening, Brief Intervention, and Referral to Treatment

SAMHSA Treatment Referral Helpline:
800-662-4357

What is a standard drink?

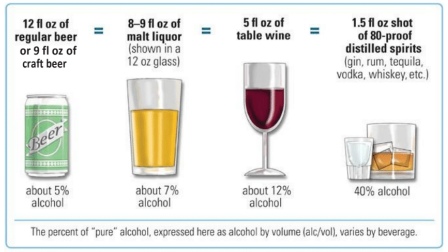
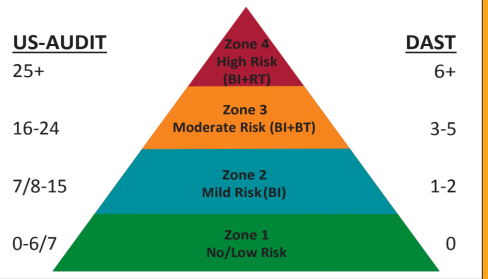


Image: NIH National Institute on Alcohol Abuse and Alcoholism

Your Risk Level



Low Risk Drinking Limits		Healthy Men < Age 65	All Healthy Women & Men ≥ Age 65	Pregnant Women	Drugs
	No more than ___ drinks per day	4	3	0	Any illicit use is considered a risk
	No more than ___ drinks per week	14	7	0	

Raise the Subject (Engage)	• Hi, my name is _____ and my role here is _____. • I'd like to take several minutes to discuss the results of the screening questions you answered today if that's OK with you.
Explore Use & Provide Feedback (Focus)	• Tell me a little bit about your use of [X]. What do you enjoy about using [X]. What do you enjoy less about using [X]? So on the one hand [Pros] and on the other hand [Cons]. • Could I share some information about your screening scores? Your scores place you in a ___risk level…[provide norms] • [Link to known consequences and personal goals]: We find that drinking 4 or more (Women) / 5 or more (Men) drinks in a few hours, drinking more than 7 (Women) / 14 (Men) drinks in a week, and/or using illicit drugs of any kind can put you at risk for social or legal problems, as well as illness and injury. It can also cause health problems like [personal health impacts] and can interfere with [personal goals]. • What do you think about that?
Enhance Motivation (Evoke)	• Let's talk about your interest in making a change. On a scale from 1-10, with 1 being not at all ready and 10 being completely ready, how ready are you to make any changes to your use? • If >1, That means you're [X}% ready to make a change! Why did you choose that number and not a lower one like _____? • If =1, What would it take to raise that number to say a 2 or 3?
Negotiate Plan (Plan)	• What might you be willing to do to reduce your risk level and stay healthy and safe? What supports do you have in making this change? • Can I share some strategies that have helped others? [recommend referral if appropriate]

1	2	3	4	5	6	7	8	9	10
Not at all ready				Somewhat ready					Extremely ready

APPENDIX

Appendix 5

Localizador de centros de tratamiento de salud conductual de SAMHSA: **findtreatment.samhsa.gov**

VA-SBIRT
Screening, Brief Intervention, and Referral to Treatment

Línea de ayuda de referencia para tratamientos de SAMHSA: **800-662-4357**

¿Qué es una bebida estándar?

Imagen: NIH National Institute of Alcohol Abuse and Alcoholism

Su nivel de riesgo

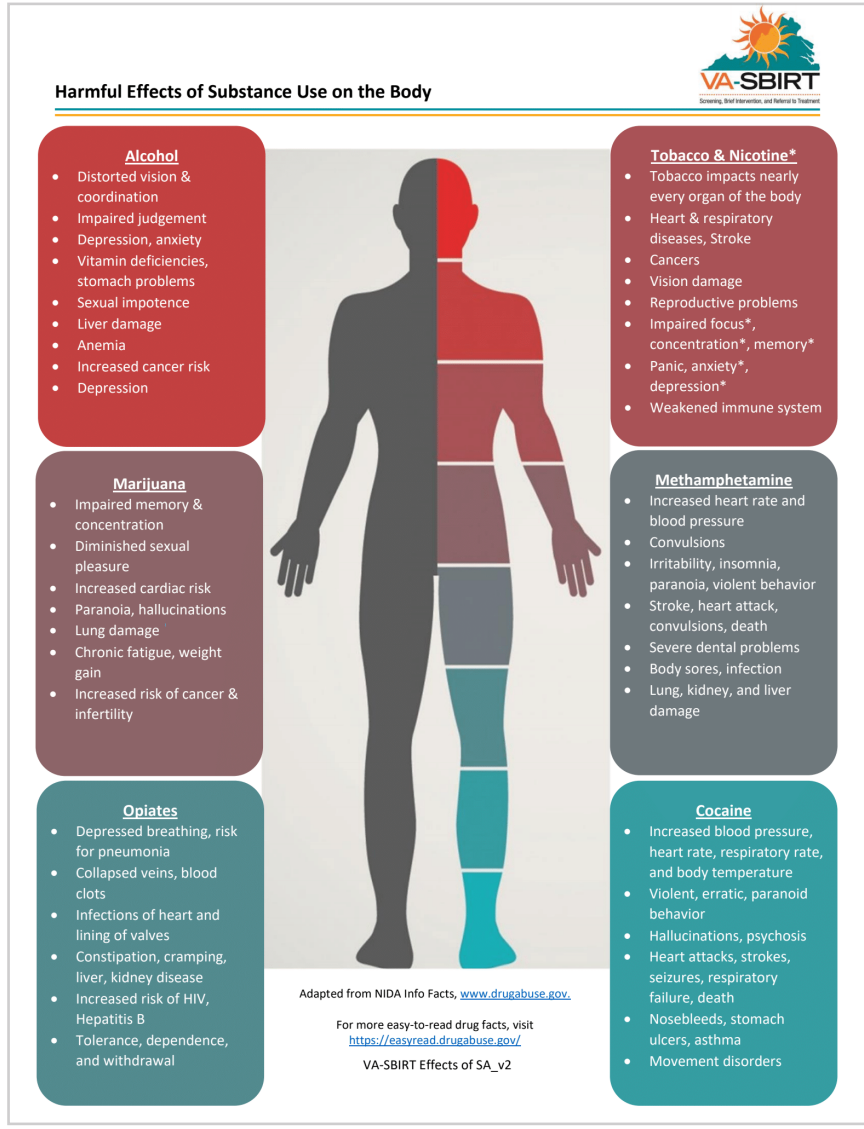
		Hombres sanos < 65 años	Todas las mujeres y hombres sanos ≥ 65	Mujeres embarazadas	
Límites de consumo de alcohol de bajo riesgo	No más de ___ bebidas al día	4	3	0	**Drogas** Cualquier consumo ilegal se considera como riesgo
	No más de ___ bebidas a la semana	14	7	0	

Plantear el problema (Comprometer)	• Si le parece bien, hablemos por unos minutos acerca de los resultados de las preguntas de evaluación que contestó hoy. • Ayúdeme a entender que es lo que disfruta de consumir [X]. ¿Qué es lo que menos le gusta de consumir [X]? • Por lo tanto, por un lado [Los puntos a favor: las cosas buenas de consumir] y por otro lado [Los puntos en contra: las cosas no tan buenas de consumir].
Proporcionar información (Enfocar)	• Sabemos que beber 4 o más (mujeres)/5 o más (hombres) bebidas en unas horas, beber más de 7 (mujeres)/14 (hombres) bebidas en una semana, y/o consumir drogas ilícitas o de cualquier otro tipo, puede llevarlo a arrastrar problemas sociales o legales, así como enfermedades y lesiones. • También puede causar problemas de salud como [X] e interferir con [metas personales del cliente].
Aumentar la motivación (Sugerir)	• En una escala del 1 al 10, donde el 1 representa no estar en absoluto listo y el 10 representa estar completamente listo. ¿Qué tan listo se encuentra para cambiar aspectos de su consumo de [X]? • Si es >1, ¡esto significa que está [X]% listo para hacer un cambio! ¿Por qué eligió ese número y no uno inferior, como por ejemplo ___? • Si es = 1, ¿qué haría falta para aumentar ese número, por ejemplo, al 2 o al 3? ¿Qué tendría que ocurrir en su vida para pensar en hacer un cambio?
Negociar un plan (Plan)	• ¿Cuáles son algunos pasos que puede tomar para "reducir los riesgos, permanecer saludable y seguro, y reducir los puntos en contra" de (del) [X]? ¿Con qué tipo de apoyo cuenta para hacer este cambio? • A continuación tenemos algunas estrategias que han ayudado a otros...

1	2	3	4	5	6	7	8	9	10
No esta en absoluto listo				Un tanto listo					Extremada-mente listo

APPENDIX

Appendix 6



APPENDIX

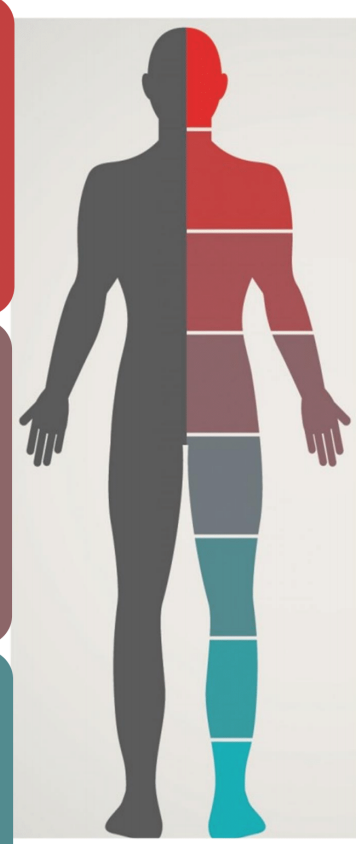
Appendix 7

Efectos Negativos del Uso de las Substancias dentro del Cuerpo

VA-SBIRT
Screening, Brief Intervention, and Referral to Treatment

Alcohol
- Coordinación y visión distorsionado
- Juicio danado
- Depresión y ansiedad
- Deficiencia de vitaminas, problemas del estomago
- Impotencia sexual
- Daño el hígado
- Anemia
- Aumenta el riesgo de cáncer

Abuso de Pastillas Narcóticas
- Riesgo de neumonía
- El colapso de las venas, coagulo de sangre
- Infección del corazón y el forro de las válvulas
- Estreñimiento, calambres, enfermedad del hígado y riñón
- Aumenta el riesgo del VIH, Hepatitis B
- Tolerancia, dependencia y síntomas de abstinencia



Marihuana
- Memoria y concentración deteriorada
- Disminución del placer sexual
- Aumento del riesgo cardiaco
- Paranoia, alucinaciones
- Daño pulmonar
- Cansancio crónico y aumento de peso
- Aumento de riesgo de cáncer y esterilidad

Metanfetamina
- Aumento del ritmo cardiaco y de la presión sanguínea
- Convulsión
- Irritabilidad, insomnio, paranoia, comportamiento violento
- Derrame cerebral, ataque al corazón, convulsión, muerte
- Problemas dental
- Llagas en el cuerpo, infección
- Daño a los riñones y el hígado

Heroína
- Riesgo de neumonía
- El colapso de las venas, coagulo de sangre
- Infección del corazón y el forro de las válvulas
- Estreñimiento, calambres, enfermedad del hígado y riñón
- Aumenta el riesgo del VIH, Hepatitis B
- Tolerancia, dependencia y síntomas de abstinencia

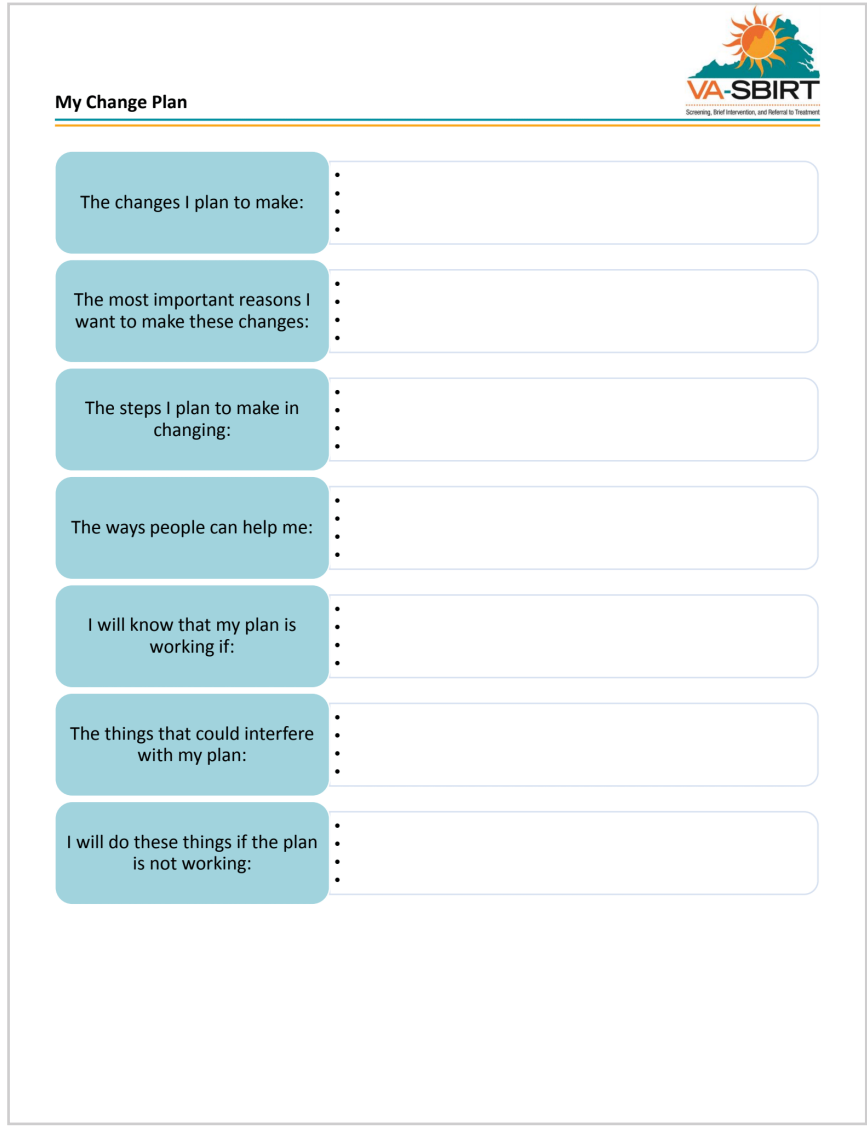
Cocaina
- Aumento de la presión, ritmo del cardiaca, temperatura, y ritmo de respiración
- Conducta errática, violento, y paranoica
- Alucinaciones y psicosis
- Ataque de corazón, convulsiones, insuficiencia respiratoria, muerte
- Asma, ulceras de estómago, y sangramiento de nariz
- Tic de la cara

Adapted from NIDA Info Facts, www.drugabuse.gov
For more easy-to-read drug facts, visit
https://easyread.drugabuse.gov/

VA-SBIRT Effects of SA Spanish_v1

APPENDIX

Appendix 8



My Change Plan

VA-SBIRT
Screening, Brief Intervention, and Referral to Treatment

The changes I plan to make:	•
The most important reasons I want to make these changes:	•
The steps I plan to make in changing:	•
The ways people can help me:	•
I will know that my plan is working if:	•
The things that could interfere with my plan:	•
I will do these things if the plan is not working:	•

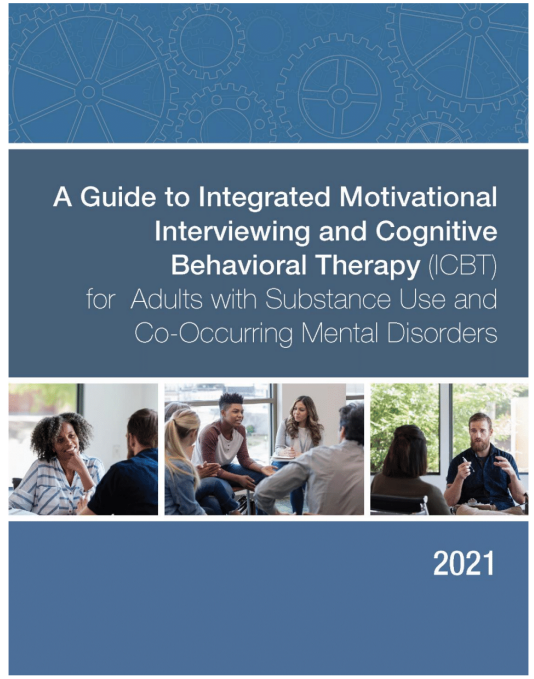
APPENDIX

Appendix 9

Brief Treatment: Integrated Cognitive Behavioral Therapy

Virginia SBIRT elected to train providers in the Integrated Motivational Interviewing and Cognitive Behavioral Therapy (ICBT) model and this was the approach promoted by SAMHSA for SBIRT projects at the time of award. This 15-session modular treatment was designed with 6 core sessions that focus on building collaboration and early recover skills while allowing remaining sessions to be individualized and customized to meet the unique needs of the individual in treatment.

The 6 core sessions include: 1) Building Rapport and Collaboration Eliciting "The Life Movie" and Change Plan, 2) Enhancing Awareness, 3) Learning Assertiveness, 4) Supporting Recovery through Enhanced Social Supports and Healthy Replacement Activities, 5) Problem Solving, and 6) Handing Urges, Cravings, and Discomfort.



Individuals interested in training in the ICBT model or accessing the guide can contact Joe Hyde at jhyde@jbsinternational.com.

APPENDIX

Appendix 10

SBIRT Perceived Competence & Readiness Assessment

VA SBIRT would like to evaluate your perceived competence and readiness for SBIRT integration. These questions take 5 minutes to complete and will be used to inform later trainings.

Agency Name:_____

Unique Identifier: _____ _____ _____ _____ 1st Initial First Name 1st Initial Last Name Month of Birth Year of Birth		
Gender (circle one): M F Transgender	**Age:** _____	**Time in Role:** _____Years _____Months
Education Level (check one): ____HS Diploma or equivalent ____Bachelor's Degree ____Master's Degree ____ MD or Doctorate Degree	**Professional Role (check one):** ____Physician/PA/NP ____Administrator ____Nurse ____Mental Health ____Case Manager Clinician/Social Worker ____Office staff ____Substance Abuse Clinician ____Other: _____	
How much familiarity have you had with SBIRT prior to today's training? (circle one) None A little Some Quite a bit A lot		

COMPETENCE: Please indicate how professionally competent you feel in performing these activities when working with patients in your setting.

	Not at All Competent	Only a Little Competent	Moderately Competent	Very Competent
Asking patients about their alcohol and drug use.				
Asking patients about quantity and frequency of alcohol and drug use.				
Screening patients for alcohol and drug problems using a formal standardized screening instrument.				
Assessing patient's readiness to change.				
Discussing/advising patients to consider reducing or halting their drinking and drug use behavior.				
Providing personalized feedback to patients about their risk associated with drinking and drug use.				
Tailoring brief interventions to patient's motivational level.				
Using open-ended questioning with patients ambivalent about cutting back or stopping use of alcohol and drugs.				
Helping patients identify benefits of cutting back or stopping use of alcohol and drugs.				
Helping patients identify challenges/barriers in cutting back or stopping use of alcohol and drugs.				
Helping patients learn from prior attempts to cut back or stop using alcohol or drugs.				
Providing patients with educational materials and resources (web, print) that can help them cut back or quit alcohol and drug use.				
Helping patients develop a personal plan for cutting back or stopping alcohol and drug use.				
	Not at All	Only a Little	Moderately	Very

SBIRT Perceived Competence & Readiness Assessment

	Competent	Competent	Competent	Competent
Conducting warm hand-offs to a colleague or specialist for patients with alcohol and drug problems.				
Arranging follow-up for patients aiming to cut down or stop using alcohol and drugs.				
TOBACCO				
Asking patients about their tobacco use.				
Discussing/advising patients to consider reducing or quitting smoking.				
Helping patients identify benefits of cutting back or stopping use of tobacco.				
Helping patients identify challenges/barriers in cutting back or stopping use of tobacco.				
Helping patients learn from prior attempts to cut back or stop using tobacco.				
Providing patients with educational materials and resources (web, print) that can help them cut back or quit tobacco use.				
Helping patients develop a personal plan for cutting back or stopping tobacco use.				
DEPRESSION				
Asking patients about their mood and associated symptoms.				
Screening patients for depression using a formal standardized screening instrument.				
Providing personalized feedback to patients about their level of depression.				
Implementing a Behavioral Activation plan.				
Providing patients with educational materials and resources (web, print) about depression.				
Conducting warm hand-offs to a colleague or specialist for patients with mild to severe levels of depression for further assessment and/or treatment.				

CONFIDENCE/EFFICACY: *How confident do you feel…* *(please circle the number that best represents your degree of confidence):*

	Not at All Confident										Extremely Confident
Reviewing the patient's previous substance use-related problems.	0	1	2	3	4	5	6	7	8	9	10
Using information gathered about the patient's substance use to provide feedback.	0	1	2	3	4	5	6	7	8	9	10
Reviewing possible reasons for decreasing substance use with the patient.	0	1	2	3	4	5	6	7	8	9	10
	Not at All Confident										Extremely Confident

SBIRT Perceived Competence & Readiness Assessment

Exploring with the patient the pros and cons of their substance use.	0	1	2	3	4	5	6	7	8	9	10
Helping a patient to agree to cut back or accept referral.	0	1	2	3	4	5	6	7	8	9	10
Identifying patients who misuse prescription medications.	0	1	2	3	4	5	6	7	8	9	10
Eliciting from a patient a goal to change his/her substance use.	0	1	2	3	4	5	6	7	8	9	10
Intervening with patients who misuse prescription medication.	0	1	2	3	4	5	6	7	8	9	10
Expressing empathy and reflecting a patient's emotions during a brief intervention for substance use.	0	1	2	3	4	5	6	7	8	9	10
Understanding a patient's mood and associated symptoms.	0	1	2	3	4	5	6	7	8	9	10
Devising a Behavioral Activation Plan with patients.	0	1	2	3	4	5	6	7	8	9	10

READINESS: *For the following items, on a scale of 0 to 10, please circle the number that best represents your degree of readiness:*

	Low Readiness					Moderate Readiness					High Readiness
How ready are you to screen all patients for alcohol use?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to provide brief interventions for patients who screen positively for alcohol use?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to screen all patients for illicit drug use or prescription drug misuse?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to provide brief interventions for patients who screen positively for illicit drug use or prescription drug misuse?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to provide brief interventions for patients who use tobacco?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to provide brief activation for patients with depressed mood?	0	1	2	3	4	5	6	7	8	9	10
How ready are you to express empathy and reflect a patient's emotions during a brief intervention for substance use?	0	1	2	3	4	5	6	7	8	9	10

What additional training would support your SBIRT integration?

THANK YOU FOR YOUR TIME!

APPENDIX

Appendix 11

SBIRT Adherence Checklist

Provider: _____ **Date**: _____ **Estimated BNI Length:** _____minutes

VA SBIRT would like to provide optimal coaching and to also assure that SBIRT is delivered with fidelity. Thus, we are asking for you to complete this self-assessment of your most recent SBIRT intervention with a patient. It is important for your own professional growth and development, as well as for overall implementation, for you to be as open and honest as possible, recognizing we all have strengths and opportunities to improve. Please place a checkmark under the corresponding definition of the degree to which you performed each aspect of SBIRT delivery. Be sure to complete both sides of the form.

Screening	**Behavior is absent**	**Behavior is present or attempted but is sparingly or insufficiently demonstrated**	**Behavior is present & meets/exceeds the expectations of good SBIRT delivery.**	**Not applicable**
Accurately assesses frequency of alcohol and/or drug use.	☐	☐	☐	☐
Uses standard drink equivalents to assess alcohol quantity.	☐	☐	☐	☐
Accurately identifies the patient's level of risk related to their alcohol or drug use using an appropriate evidence-based screening instrument.	☐	☐	☐	☐
Brief Intervention				
Raise the Subject and Provides Feedback				
Respectfully asks permission to discuss substance use and/or screening results.	☐	☐	☐	☐
Elicits the pros and cons of substance use.	☐	☐	☐	☐
Reflects or summarizes any patient discrepancies.	☐	☐	☐	☐
Provides patient-relevant medical information.	☐	☐	☐	☐
Elicits patient response to feedback.	☐	☐	☐	☐
Assess Readiness				
Assesses patient's readiness to change using readiness ruler.	☐	☐	☐	☐
Enhances motivation (asks why not a lower number or, if 0, what would have to happen to consider change).	☐	☐	☐	

SBIRT Adherence Checklist

Negotiate a Plan	**Behavior is absent**	**Behavior is present or attempted but is sparingly or insufficiently demonstrated**	**Behavior is present & meets/exceeds the expectations of good SBIRT delivery.**	**Not applicable**
Collaboratively negotiates a goal with the patient including steps they are willing to take.	☐	☐	☐	☐
Respectfully offers advice / provides suggestions.	☐	☐	☐	☐
Arranges a follow-up and/or referral to treatment.	☐	☐	☐	☐
Summarizes the action plan.	☐	☐	☐	☐
Thanks the patient for discussing substance use.	☐	☐	☐	☐
Motivational Interviewing Spirit				
Uses open-ended questions.	☐	☐	☐	☐
Affirms patient's strengths, ideas, and/or successes.	☐	☐	☐	☐
Uses reflections (repeating, rephrasing, paraphrasing, or reflection of feeling)	☐	☐	☐	☐
Uses summaries.	☐	☐	☐	☐

Overall Comments (e.g., Strengths, areas for improvement):

APPENDIX

Appendix 12

SBIRT TeleECHO Clinic

What Is SBIRT?
SBIRT (Screening, Brief Intervention and Referral to Treatment) is a comprehensive, evidence-based, public health approach to the early identification, intervention and treatment for persons along the continuum of substance use risk.

Where Can It Be Used?
This innovative tool is designed to be used by staff at any range of healthcare settings, such as primary care centers, hospital emergency rooms, and other settings that could provide behavioral or medical services (e.g., schools, criminal justice settings).

Why SBIRT?
Because the research shows it helps individuals avoid the **severe and deadly consequences** of active or potential substance use disorders.

HOW TO PARTICIPATE IN OUR SBIRT TeleECHO CLINIC

- Complete on-line registration
- Participate in didactic presentations and discussion of cases.
- Present cases via Zoom video connection or by telephone.
- Complete on-line evaluation forms to receive Continuing Education Units.
- Participants may be asked to complete periodic surveys evaluating knowledge and self-efficacy related to SBIRT delivery.

TeleECHO Clinic Facilitators

Patty Ferssizidis, PhD
Licensed Clinical Psychologist
Assistant Professor, GMU
VA-SBIRT Principle Investigator

Rotating SBIRT Experts

Jordan Daylor, MA Clinical
Psychology George Mason University

SBIRT TeleECHO™ Contacts

Patty Ferssizidis, PhD - Clinic Lead
Phone: 703-993-1932
Fax: 703-993-1942
E-mail: pzorbas@gmu.edu

Jordan Daylor — Program Coordinator
Phone: 703-239-4644
Email: jdaylor@gmu.edu

IT Support — Sai Donthula
Email: sdonthul@masonlive.gmu.edu

sbirt.gmu.edu

To register, or for more information, please contact our Program Coordinator!

VA-SBIRT
Screening, Brief Intervention, and Referral to Treatment

SBIRT TeleECHO™ Clinic

Curriculum
March - August 2019

Project ECHO
George Mason University Virginia

We Would Like to Invite You to Enroll in the SBIRT TeleECHO Clinic

Virginia SBIRT and George Mason University welcome you to participate in our biweekly SBIRT TeleECHO clinic. The curriculum will build on itself and is designed to help providers less familiar with the identification and intervention of substance misuse to become familiar and then proficient in the screening and intervening with patients across the continuum of substance risk. We encourage providers to present cases for discussion.

Standardized Continuing Education Units are available for those who complete on-line registration and post-session evaluations.

Any healthcare provider (including mental health providers, physicians, physician assistants, nurse practitioners, nurses, medical assistants, pharmacists, case managers, community health workers, prevention specialists, etc.) with an interest in SBIRT who has completed an initial SBIRT training is welcome to participate.

All participants are asked to complete an on-line PIF (Participant Information Form) once a year and an on-line evaluation for each session attended. For confidentiality, HIPPA compliance, and professionalism, please identify yourself when you join each teleECHO clinic so that we can verify that you are a qualified healthcare professional. TeleECHO clinics are not open to the general public or patients.

Course Schedule: First and third Monday of each month, 12:00-1:30 PM, Eastern Time.

Goals of the SBIRT TeleECHO Clinic

Participants will be enabled to:

1) Increase knowledge of an evidence-based approach to the identification & management of substance risk.

2) Provide brief intervention and make assertive referrals for treatment.

3) Participate in our regional SBIRT community of practice.

Additional SBIRT Education Resources

- Substance Abuse & Mental Health Services Administration
  - https://www.samhsa.gov/sbirt
- Addiction Technology Transfer Center Network
  - https://attcnetwork.org/northwest-sbirt

sbirt.gmu.edu

SBIRT TeleECHO Clinic Curriculum March - August 2019

A Typical SBIRT TeleECHO Clinic

12:00 - 12:10 .....Introductions
12:10 - 12:30.....Didactic
12:30-12:40.....Q & A
12:40-1:30.....Case Presentations

March

4th The Intersection of ADHD, Stimulants, & Marijuana (Observation session for New Participants)

18th Orientation to New Participants

April

1st *Open Topic*

15th Advanced MI: When Agendas Differ

May

6th *Open Topic*

20th Psychopharmacology

June

3rd Open Topic

17th Alternative Pain Management Techniques

July

1st *Open Topic*

15th Improving Sleep

August

5th *Open Topic*

19th Intimate Partner Violence

Possible Open Topics

Anxiety & Substance Use Disorders

Clinical Burnout - How to Build Resiliency

Harm Reduction Principles

How to Get Reliable Patient Self-Report on Sensitive Topics

Mental Health and Substance Use Disorders in LGBT Patients

Neurobiology of Addiction

Pharmacotherapy for Alcohol Use Disorder

Seeking Safety Treatment for Substance Use Disorder & PTSD

SBIRT with Pregnant & Parenting Women

SBIRT with Adolescents

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VA-SBIRT Final Report

NOVEMBER 2021

Changing lives one screen at a time…