ATTC Addiction Technology Transfer Center Network
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ATTC WHITE PAPER:

BUILDING CAPACITY FOR BEHAVIORAL HEALTH SERVICES WITHIN PRIMARY CARE AND MEDICAL SETTINGS

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ATTC
Advancing the Integration of Substance Use Disorder Services and Health Care

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Foreword

Workforce development is the central priority of the ATTC Network. Each regional and national focus area ATTC is uniquely suited to strengthen the knowledge, skills, and attitudes of behavioral health and primary care providers by delivering training and targeted technical assistance (TA) regarding SUD identification, treatment and recovery. The training and TA provided on evidence-based skills and change implementation strategies can be used to assist organizations in moving towards fully integrating medical care, mental health, and substance use disorder services.

This white paper is intended to provide a series of recommendations to guide practitioners in achieving more integrated behavioral health services in their respective settings. The paper presents Screening, Brief Intervention, Referral to Treatment (SBIRT) as a guiding clinical framework and identifies organizational change activities that are necessary to fully implement integrated treatment models. Regional and National ATTCs are available to providers to support these efforts through targeted training and technical assistance initiatives.

The target audience for this paper includes clinic administrators, health care professionals, social workers, behavioral health counselors, substance use disorder counselors, community health workers, and other allied professionals in primary care and behavioral health integration settings. Since Federally Qualified Health Centers (FQHCs) are expected to take a leading role in health care reform, this paper focuses primarily on the integration of behavioral health services within FQHCs. Nevertheless, the considerations outlined in this paper are applicable to a wide range of medical settings operating under several different models of care.

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Building Capacity for Behavioral Health Services Within Primary Care and Medical Settings

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Introduction

Building Capacity for Behavioral Health Services within Primary Care and Medical Settings is the second in a series of white papers produced as part of the Addiction Technology Transfer Center (ATTC) Network's initiative, "Advancing the Integration of Substance Use Disorder Services and Health Care." The main goals of this white paper series are to emphasize the need for better integration of substance use disorder (SUD) and health care services and describe an array of effective models, interventions and implementation strategies for treating SUDs in health care settings, highlighting efforts of the ATTC Network.

The ATTC Network is the Substance Abuse and Mental Health Services Administration's (SAMHSA) most experienced program providing workforce development and promoting the adoption and implementation of research-based interventions in the SUD field. The ATTC Network employs a full array of technology transfer techniques, including product development, academic education, training, technical assistance and skills building, online and distance learning, coaching and implementation support/guidance, to help individuals, organizations and systems prepare for, make, and sustain change.

Comprised of ten Regional Centers that align with the ten Department of Health and Human Services (HHS) regions, four National Focus Area Centers and a Network Coordinating Office, the ATTC Network has both a national reach and a targeted regional/state emphasis. At the national level, the Network collaborates and partners with many national SUD and behavioral health care organizations to produce projects that have an impact nationwide. At the regional/state level, ATTCs reach deep into local communities and are able to customize services to meet the needs of a particular area.

ATTC expertise in implementation science/technology transfer strategies combined with the complementary national and regional reach of the various Centers situates the ATTC Network in an ideal place to promote and facilitate efforts to integrate SUD services and health care.

Treatment Gap for Substance Use Disorders

A large majority of persons with substance use disorders (SUDs) do not seek or receive treatment in the specialty care substance abuse treatment system. According to the 2014 National Survey on Drug Use and Health (NSDUH), of the 22.5 million people aged 12 or older who needed treatment for a problem related to the use of alcohol or illicit drugs, there were an estimated 4.1 million people who received any substance use treatment in the past year; only 2.6 million people received treatment at a specialty facility. Thus, nearly 20 million people needed substance use treatment in 2014 but did not receive specialty treatment; however, the large majority of these approximately 20 million people reported that they felt they did not need treatment. Of those who did perceive a need for treatment, the two most commonly reported reasons for not receiving treatment at a specialty facility were that they were not ready to stop using or that they had no health coverage and could not afford the cost of treatment.

This large treatment gap does not account for tens of millions of Americans who engaged in both recreational and harmful use of illicit drugs or alcohol within the past year (McLellan, 2009). The majority of this group did not meet the criteria for needing specialized substance abuse treatment (hospital inpatient, drug or alcohol rehabilitation, or mental health services). According to the 2014 NSDUH, an estimated 27 million Americans aged 12 or older (10.2%) used an illicit drug during the month prior to the interview; 52.7% reported being current drinkers of alcohol, 23% reported binge patterns of drinking (i.e., having 5 or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey), and 6.2% reported heavy drinking (i.e., binge drinking on at least 5 days in the past 30 days); and 66.9 million (25.2%) were past month users of tobacco products (CBHSQ, 2015).

Integration Under the Affordable Care Act

As outlined in the ATTC Network's Issue Brief, *Advancing the Integration of Substance Use Disorder Services and Health Care* (Addiction Technology Transfer Center [ATTC] Network, 2014), and the ATTC White Paper, *Integrating Substance Use Disorder and Health Care Services in an Era of Health Reform* (ATTC Network, 2015), health care reform presents a unique opportunity to address the behavioral health needs of millions of Americans.

Specifically, the Affordable Care Act (ACA) expands mental health and substance use disorder benefits and federal parity protections for more than 60 million Americans by:

- Including mental health and SUD benefits as Essential Health Benefit categories,
- Applying federal parity protections to mental health and substance use disorder benefits in individual and small group markets, and

Providing millions of previously uninsured Americans with access to quality health care that includes coverage for mental health and SUDs (Beronio, Po, Skopec, & Glied, 2013).

With full implementation of the Affordable Care Act, more Americans have access to health insurance that includes coverage for substance use disorders. Because the majority of individuals with these problems do not seek treatment in specialty settings (Institute of Medicine [IOM], 2001; SAMHSA, 2011a), primary care settings will often be the most viable gateway to services for this population (DiLonardo, 2011). Hence, Federally Qualified Health Centers (FQHCs) are expected to take a leading role in health care reform, and therefore must

As of September 2015, 17.6 million Americans were enrolled in ObamaCare. This is up from previous estimates of 16.4 million in March 2015 (ObamaCare Facts, 2015). Under the ACA, the uninsured rate has fallen from a high of 18% to below 11.4% (the lowest uninsured rate in 50 years), a greater than 35% reduction in total uninsured.

develop quality services to prevent and treat addiction. Medical providers must be adept at identifying those who are exhibiting patterns of harmful substance use so they can intervene before it progresses and develop strategies to assist patients in reducing their substance use, including referral.

Implementing Integrated Models of Care

To address behavioral health issues adequately, medical providers must be able to identify and implement more integrated models of care, defined by SAMHSA as "the systematic coordination of general and behavioral health care." Integrating mental health, substance abuse, and primary care services produces the best outcomes and is the most effective approach to caring for people with multiple healthcare needs. (SAMHSA-HRSA Center for Integrated Health Solutions [SAMHSA-HRSA CIHS], 2014). Integrating mental health and substance abuse treatment into primary care and other medical settings is feasible, can be accomplished through a variety of strategies with diverse patient populations, has been shown to produce the best outcomes, and is the most effective approach to caring for people with multiple health care needs (Crowly & Kirschner, 2015).

Traditionally, integration has been conceptualized as occurring along a continuum of coordination, collaboration, co-location, and full integration. However, as health reform has increased demand on the health care system and modern health care has grown increasingly complex, practitioners have had to adapt their approaches to treat chronic illness effectively in primary care settings. The challenge is that in most instances there remains a lack of clinical consensus about the appropriate scope of behavioral health practice in the primary care setting, and more specifically, limited knowledge about the most effective models of integrated care.

What is Known about Behavioral Health Integration in Medical Settings

In 2010, the National Association of Community Health Centers (NACHC) conducted a comprehensive assessment of behavioral health services provided in FQHCs that helped to identify the degree to which health centers have attained integration of services and establish a better understanding of behavioral health staffing (Lardiere, 2011). The assessment was sent to 1,080 FQHCs, and 420 non-duplicate responses were received (a 38.9% response rate). A large majority, 83% (n=348), of FQHCs reported that they do provide mental health or substance abuse services onsite or maintain formal linkages with specialty care providers. The remaining 17% (n=72) did not provide any behavioral health services and therefore were precluded from completing the assessment. Thus, results focus on the 348 FQHCs that do provide behavioral health services and indicate that although there is substantial work to be done, significant progress toward behavioral health integration had been made at the time of the assessment:

Integrated care is "the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs."

SAMHSA-HRSA Center for Integrated Health Solutions, 2014.

1. Of FQHCs assessed, 65% met all components of integrated care, i.e., services are co-located on site, they have good communication and coordination among behavioral health and primary care providers, they share behavioral health treatment plans, they share problem lists and medication and lab results, and behavioral health and medical providers make joint decisions on treatment.

2. Almost all FQHCs (n=346) provide mental health services, while 55% of FQHCs (n=192) provide substance abuse services.

3. The large majority of centers provided mental health and/or substance abuse services onsite; much fewer reported using formal contractual arrangements.

4. Most FQHCs that provide onsite behavioral health services use staff that are employed by the Center; few use staff outsourced from another agency.

5. FQHCs reported employing a total of 2,582.52 FTE behavioral health care providers, of which 31% were social workers; 21.5% "other" behavioral health professionals; 10.1% professional counselors; 9.2% "other" master's level; 8.6% psychologists; 6.9% psychiatrists; 6.2% addiction counselors; 3.8% nurses; and 2.6% marriage and family counselors.

Workforce Development to Support Integrated Care

Perhaps one of the most significant barriers to the implementation of integrated behavioral health services within primary care and other medical settings is the perception and belief among medical staff that they do not possess the necessary competencies to implement the enhancements that are subsequently outlined in this paper. Indeed, a survey of 68 primary care clinicians at five FQHCs in Los Angeles showed that while clinicians routinely address patients' drug use, they feel unprepared to assess and treat SUDs (Reddy, Anderson, & Gelberg, 2015).

In this regard, it is the responsibility of the management team in every primary and specialty care setting to ensure that staff develop the competencies necessary to effectively implement integrated care initiatives. This can be ensured via the implementation of an organization-wide tailored workforce development plan that prescribes the training and TA necessary to improve staff competencies identified as essential for supporting the organizational change.

Key Ingredients of Workforce Development Strategies to Integrate Care

Build an organizational culture that is supportive of integrated care

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

Consider team-based care as the ideal staffing model for integration

Expand the delivery of evidence-based practices

Competencies for Integrated Care

Despite the increasing focus nationally on integrated care, there is no single, widely recognized set of competencies on this service approach for either the behavioral health or the primary care workforce (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). However, there are at least three sets of proposed competencies from which organizations might wish to develop tailored goals. The following paragraphs describe these competencies. (See Appendix A for detailed lists.)

Agency for Healthcare Research and Quality (AHRQ)

Kinman, Gilchrist, Payne-Murphy, & Miller (2015) conducted a literature review in order to understand current thinking about workforce competencies with regard to integrated behavioral health in primary care. This literature review identified the competencies necessary for providers and staff who work in an integrated primary care setting. The review process identified articles that addressed practice- or system-level competencies necessary to achieve effective integration. The resulting review highlights a set of competencies, practices, providers, and staff required to advance integration efforts and provide comprehensive care to improve patient outcomes.

Association for Medical Education and Research in Substance Abuse (AMERSA)

Haack & Adger (2002) developed a strategic plan to inform the government and others on how to improve substance abuse education for generalist health professionals—i.e., those who do not specialize in the addictions yet routinely see patients who use alcohol, tobacco, and other drugs in a risky or problematic manner.

SAMHSA - HRSA Center for Integrated Health Solutions (SAMHSA-HRSA CIHS)

SAMHSA-HRSA CIHS (2014) developed core competencies intended to serve as a resource for provider organizations as they shape job descriptions, orientation programs, supervision, and performance reviews for workers delivering integrated care. The competencies are to be a resource for educators as they shape training programs on integrated care. The charge was to develop a "core" or "common" set of competencies relevant to working in diverse settings with diverse populations. The competency sets are not intended to be setting- or population-specific. Their principal relevance is to the integration of behavioral health with primary care as opposed to the integration of behavioral health with specialty medical care.

To support integration efforts at the programmatic level, this paper recommends workforce development strategies to ensure that staff develop the competencies necessary to work in an integrated care delivery system. Although a variety of competencies are addressed throughout the paper, the recommendations made focus on the following key ingredients:

Build an organizational culture that supports integrated care as the foundation for any change initiative;

Implement SBIRT, which provides a practical framework for behavioral health capacity building in medical settings;

Consider team-based care as the ideal staffing model for integration;

Expand the delivery of evidence-based practices to promote continued improvements in patient health; and

Practice routine clinical supervision to ensure the necessary staff and programmatic development.

1. Building an Organizational Culture Supportive of Integrated Care

Managing Organizational Change Initiatives

Much has been written about the nature of organizational change and the best methods to facilitate, implement, and manage change initiatives. Based on a growing body of research, a better understanding now exists of the processes that are most integral to the success of organizational change initiatives. Essentially, changing the goal or the direction of an organization often means changing work responsibilities for a large majority of employees. However good the intention, employees will often react with resistance, which can jeopardize effective organizational transformation.

Diamond (1996) illustrates the underlying psychological dynamics of organizational change in his article, "Innovation and Diffusion of Technology: A Human Process." The article demonstrates the need for experts and managers to recognize the human processing of and resistance to change and learning. Asking staff to approach their work differently requires them to make a cognitive shift, resulting in emotional demands on their feelings of competence. This increases the individual's stress, especially when there is a lack of information, uncertainty, and a lack of participation. Until workers feel ownership of the new system, they may feel anger or anxiety. Providing a "transitional space" allows members of the organization to work through their feelings. During this process, workers will need to acknowledge what they are losing and what they are gaining. To some degree, it is a four-phase grief process (numbing, yearning, disorganization and despair, reorganization). Providing a forum to facilitate this process increases the likelihood of successful implementation.

Efforts required to achieve integration of behavioral health services within medical settings are both substantial and complex, and given what appears to be a daunting challenge, many providers may be reluctant to invest in such efforts. The following strategies may enhance integration efforts and minimize resistance to change.

Obtain Leadership Support

Leadership buy-in and involvement, in other words "top-down support," is essential to the successful implementation of any new innovation (Dezdar & Ainin, 2011; Forsner, Hansson, Brommels, Wistedt, & Forsell, 2010; Hung, Chen, & Wang, 2014). Because leaders

of an organization influence company culture, their lack of buy-in and commitment to any innovation would all but ensure that these interventions will not be adopted in practice, embraced by staff, or implemented to their full potential. Most importantly, absent the support of leadership, the resources necessary to facilitate implementation may not be made available to staff who are implementing a new practice, and organizational barriers that emerge during implementation are unlikely to be effectively addressed. Therefore, all workforce development initiatives undertaken to enhance integrated care should engage executive leadership to establish the foundation for implementation success.

Solicit Staff Participation

When implementing change initiatives, it is vital to involve the entire organization. Changing organizational goals without consulting with staff will often result in opposition by and demoralization of employees. Research suggests that people are more likely to invest in and commit to organizational policies that they have helped to shape, as opposed to policies that have been imposed upon them (Cotton, 1995; Sagie, 1995; Wanberg & Banas, 2000). In fact, research has shown that, even when staff is not directly involved in the decision, people are more willing to accept administrator-derived policies when their input is considered during the actual implementation process (Sagie, Elizur, & Koslowsky, 1990, 1995). Thus, it is critical to ask for staff participation throughout the implementation process. Simply put, once staff are made aware of the change to be implemented, they should be given the opportunity to shape that change. The best way to plan for change is to solicit knowledge from staff already familiar with the job at hand. From the perspective of leadership, this would acknowledge that "we know more than me."

Establish a Change Process

Although leadership buy-in and staff input are necessary for the successful implementation of new initiatives, they are not sufficient.

That is, the motivation to change, even when accompanied by a tentative plan for achieving that change, will likely lose momentum and fall short of the intended goal without the benefit of a more structured framework for managing implementation efforts. Given the complexity of efforts required to achieve the integration of behavioral health services within medical settings, challenges to implementation will arise that must be promptly addressed to ensure success. Having a structure in place to manage the change effort will ensure that this occurs. This can be done via formally structured "change teams" or informal partnerships between staff (NIATx, 2014).

Identify Organizational "Champions" or "Change Agents"

Once a change process has been established, it will be important to identify staff who will be responsible for managing the change initiative. In health care, there is long-held wisdom that champions are a key aspect of organizational change. Champions are staff members who voluntarily take an interest in a policy, program, or project, advocating for its adoption and encouraging implementation throughout the organization, which often will include negotiation through entrenched internal resistance to change. Simply put, select staff can function as "purveyors" (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) or "change agents" (Havelock & Havelock, 1973) to guide implementation of a programmatic practice. Without these individuals to manage various critical aspects of implementation, the proposed initiative will lack credibility and efforts are likely to lose focus and momentum.

Develop an Implementation Plan

With the infrastructure in place for the proposed change initiative, it is important to develop an organization-wide implementation plan that specifies goals and objectives for enhancing integrated care. This plan will specify the types of procedures and services to be implemented and will serve as the working document that informs change team activities. Initially, the plan should focus on short-term, achievable, and measurable goals and objectives that are critical to establishing a foundation for a more sustainable model of integrated care. The plan should outline what is to be accomplished, by whom, by when, and how. Without the benefit of a structured implementation plan, efforts to integrate behavioral health services will lack needed direction, and again, are likely to lose focus and momentum. Implementation plans should be revised often as specific goals/objectives are met to establish new goals and to adjust in response to barriers faced and lessons learned.

Implement Ongoing Quality Improvement Process

The change team should monitor the implementation plan closely to ensure that integration efforts are proceeding as planned. A popular mechanism or framework for this is the Plan Do Study Act (PDSA) cycle (Shewhart, 1939). The **Plan** step involves identifying a goal or purpose, defining success metrics, and putting the plan into action. The **Do** step involves implementing the components of the plan. The **Study** step involves the monitoring of outcomes for signs of progress and success, or problems and areas for improvement. The **Act** step integrates the learning generated throughout the process, which can then be used to adjust the goal, change methods for achieving the goal, or reformulate altogether. These steps are repeated as part of a continuous cycle of quality improvement

The ATTC Network has developed practical applications for facilitating integration, and the following are two widely disseminated resources:

1. The ATTC Technology Transfer Model is a multi-tiered change process used for successful implementation of evidence-based practices that assists stakeholders in determining how to best utilize limited resources to increase the use of evidence-based practices (EBPs; ATTC Network, 2011); and

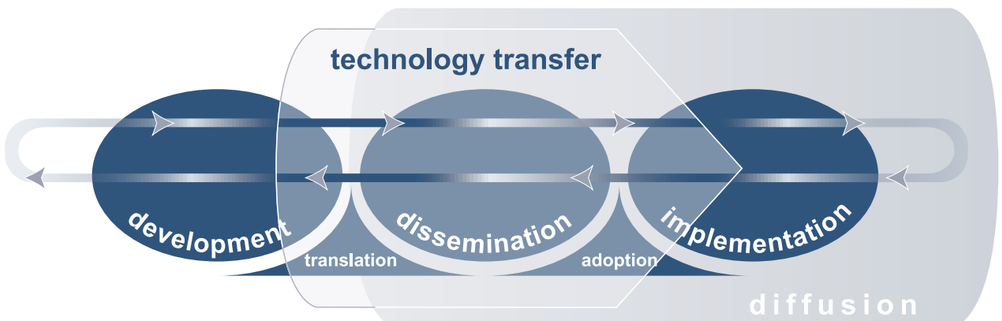

Figure 1. ATTC Network Technology Transfer Model

2. The Change Book is a landmark technology transfer tool designed to assist both practitioners and organizations to improve prevention and treatment outcomes across systems (ATTC Network, 2010) by offering principles, steps, strategies and activities for implementing change initiatives at the organizational level.

Recommendations for Managing Organizational Change

Solicit training and technical assistance in organizational change models that will help to:

1. Engage leadership
2. Identify effective ways to solicit staff input
3. Develop a change process
4. Identify change champions or agents
5. Draft implementation plans
6. Monitor ongoing quality improvement

Promoting Cultural Change

Organizing a change process, identifying key staff to manage that process, and developing an implementation plan to guide that process will provide the critical infrastructure necessary for ensuring that the initiative has the chance to succeed. However, the successful implementation of any change initiative requires the full support of all program staff to succeed long-term. That is, the goals and objectives outlined in the implementation plan cannot be achieved with consistency unless all staff who play a role in implementation are committed to the tasks involved.

Thus, integrating behavioral health care services within routine medical settings will likely require a sea change in organizational and staff culture. Primary care providers have been trained to provide general medical services and often consider behavioral health services outside of the realm of their responsibility. Further, asking primary care physicians and medical staff to take responsibility for their patients' behavioral health needs will have an adverse impact on workloads. Given this reality, staff receptivity to integrated treatment may initially be quite limited. As a result, the process of culture change for many organizations must be an ongoing focus for leadership and needs to be proactively addressed. One of the best ways of avoiding resistance is through clear communication beforehand and staff education. Don't assume that all staff will see the wisdom and value in this new direction.

Recommendations for Promoting Cultural Change

1. Engage all staff in a team discussion on their"attitudes and values" regarding integrated behavioral health care. Any resistance that is present among staff will become evident and it will provide an opportunity to work through the issues.
2. Share with staff the organizational vision for building integrated care. This should include the general direction the organization is pursuing, as well as the implementation plan once it has been developed. This will help to clarify the specific activities that will be taking place and what is expected of staff.
3. Provide basic training in attitudes, prevalence, common signs and symptoms, detection and triage for substance use and mental health disorders. Staff may be initially resistant due to concerns about whether they possess the necessary competencies and skills to provide the services to this more complex population.

2. SBIRT as a Framework for Behavioral Health Capacity Building

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive public health approach for delivering early intervention and treatment services to people with, or at risk of developing, SUDs (Office of National Drug Control Policy [ONDCP], 2012). SBIRT can be implemented in medical settings, including community health centers, and has also demonstrated some success in hospitals, emergency departments, specialty medical practices (e.g., HIV clinics), and workplace wellness programs (SAMHSA-HRSA CIHS, 2014). In these settings, SBIRT enables health care professionals to systematically screen and assist a large segment of the population who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family. SBIRT has often been conceptualized as a four-part process consisting of the following (ONDCP, 2012):

Universal screening quickly determines the likely presence of a substance use or mental health disorder and whether there is a need for further assessment to identify the severity of the disorder and the appropriate level of treatment.

Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of substance use or mental health issues and their consequences and motivating them toward positive behavior change.

Brief therapy is for persons who would benefit from more than a brief intervention. Brief therapy includes further assessment, education, problem solving, coping mechanisms, and building a supportive social environment.

Referral to treatment provides a referral to specialty care for persons deemed to be at-risk who are in need of substance abuse or mental health treatment. Treatment provides medication, behavioral counseling, and recovery support in combinations that best meet a patient's needs.

In the context of efforts to integrate behavioral health services in medical settings, SBIRT provides a realistic framework for integration, helping programs to prioritize the ways in which staff competencies should be enhanced to support patient care. Given the responsibility health care practitioners have to look after patients' overall well-being, they must be equipped to identify a host of potential health problems, including substance use and mental illness. SBIRT offers medical practitioners the tools and skills necessary to identify these individuals via screening and to provide brief interventions that can address low risk and harmful or risky use, which will be evident in a great number of patients who would not otherwise seek specialty care.

At the same time, through an emphasis on referral to treatment, SBIRT recognizes that medical settings are typically not equipped to provide intensive treatment such as counseling and recovery support to individuals with more severe disorders. Thus, SBIRT is designed to prevent the unhealthy consequences of alcohol and drug use or mental illness among those who have not reached the diagnostic level of a substance use or mental health disorder, and to help those with the disease of addiction or mental illness to enter and engage in treatment. The following sections outline an approach to workforce development that emphasizes capacity building for staff in several areas posited to be key to the implementation of an SBIRT-type approach.

The National SBIRT ATTC is funded to advance SBIRT as a timely public health model worthy and in need of advancement to reach its full potential impact on the health of Americans. In partnership with the University of Chicago's National Opinion Research Center (NORC), the National SBIRT ATTC aims to help healthcare providers utilize the public health model of screening for substance use and providing advice or counseling to their patients who use alcohol or other drugs in risky or harmful ways. The National SBIRT ATTC has provided training and technical assistance to specific health care groups, to assist with the implementation of SBIRT. For more information, visit: http://www.nattc.org/national-focus-areas/?rc=sbirt

Ultimately, the widespread use of SBIRT across health care settings, including emergency rooms, community clinics, and trauma centers, requires SBIRT coding and billing policies that support implementation. Currently, coding and reimbursement are dependent upon the payer type; reimbursement is available through commercial insurance Current Procedural Terminology (CPT) codes, Medicare G codes, and Medicaid Health Care Common Procedure Coding System (HCPCS) codes. While Medicare currently pays for screening and brief intervention as a preventive service in the primary care setting, some states have recently activated, or are working to activate Medicaid codes for SBIRT reimbursement to allow providers to bill and receive payment for the services. Even with reimbursement codes available, it is important to note that some states may still have difficulty covering screening and brief intervention services when non-physician professionals provide them.

Addressing SBIRT reimbursement barriers not only expands use of SBIRT, but assists in the sustainability of providing these services in the primary care setting.

The National Screening, Brief Intervention & Referral to Treatment ATTC

In the current funding cycle the ATTC Network has a national focus area ATTC on Screening, Brief Intervention, and Referral to Treatment. The aim of the National SBIRT ATTC is to increase systems-level implementation of SBIRT approaches. Many regional ATTCs have engaged with the National SBIRT ATTC in broad-scale SBIRT training and implementation support projects to move individual providers, county systems, and large care networks toward the use of alcohol and drug screening and brief intervention with fidelity.

ATTCs have been successful in convening large health care integration summits, conferences, and symposia to bring together providers from a variety of care settings to foster a dialogue around the facilitators and barriers to integrated care delivery. The ATTC network has also provided technical assistance to organizations to determine the extent to which their current approaches and practices are suited for integrated care delivery.

Screening for Behavioral Health Disorders

Screening is a formal process of determining whether a patient warrants further assessment in regard to a particular disorder (SAMHSA, 2005). The screening process for a substance use or mental health disorder seeks to answer a "yes" or "no" question: Does the patient being screened show possible signs of a substance use or mental health problem? The screening tool does not identify the particular nature of that problem (e.g., distinguish between depression and anxiety) or its severity, but simply determines whether further assessment is warranted.

Screening is regarded a best practice as it effectively facilitates a "No Wrong Door" approach, which is an essential principle of integrated care (CSAT, 2000). Although the "No Wrong Door" approach originally related to the integration of mental health and substance use treatment, it is broadly applicable to all integration efforts as it denotes a system of care that is accessible from multiple entry points, provides treatment for multiple disorders, and collaborates with all entities involved. The "No Wrong Door" approach is vital to identification of behavioral health disorders in medical settings, and can help to overcome any "culture clash" that may exist.

Selecting a Validated Substance Use and Mental Health Screening Tool

Many elements should be considered when making a determination as to the most appropriate screening tool to adopt and implement. Ultimately, an organization must select a tool that will suit the needs of both the agency and patient population. With regard to agency needs, the primary considerations or driver would be staff resources and clinical workflow, as these factors will influence who administers the screening tool and how the process is integrated. With regard to patient population, cultural or linguistic needs must be considered, along with specific behavioral health issues that must be explored during the intake process. Nevertheless, medical settings typically characterized by a high volume of patients and limited resources should prioritize the following factors when selecting a screening tool for substance use and mental health disorders:

1. Duration of administration. Select a screening tool that does not require significant staff time to administer. Many substance use and mental health screens can be administered in less than 10 minutes and provide comprehensive information for what should be the next steps.

2. Cost of administration. Select a screening tool that is available in the public domain and accessible for download free-of-charge to the provider. Many substance use and mental health screening tools are currently readily accessible to providers and can be implemented free-of-charge.

3. Preparation for administration. Select a screening tool that does not require any in-depth specialized training for administration or one that can be self-administered by the patient. The clinician can administer most tools simply by asking the questions verbatim, recording "yes" and "no" responses accurately, and scoring results according to the instructions that are provided (scoring may require a basic count of "yes" responses).

4. Validation. Select a screening tool that has been validated for the target population, setting, and/or disorder. A validated screening instrument is one that has been shown to measure what it is intended to measure. Results for validated instruments are readily available in the literature.

5. Accuracy. Screening instruments are typically evaluated for sensitivity and specificity, which speak to an instrument's ability to correctly identify those patients as "at-risk." Sensitivity, the true positive rate, refers to the proportion of "positive" patients who are correctly identified as such. Specificity, known as the true negative rate, refers to the proportion of "negative" patients who are correctly identified as such. A perfect predictor would be 100% sensitive and 100% specific; however, for any screening tool there is usually a trade-off. That is, it would be important to determine whether the goal is to minimize "false negatives" or "false positives." If resources are limited, you might select a screening tool with high specificity that minimizes the number of false positives (i.e., healthy individuals who screen positive) so that staff don't get burdened with conducting follow-up assessments for healthy patients. If you have more resource flexibility, you might select a screening tool with high sensitivity that minimizes the number of false negatives (i.e., sick individuals who screen negative) to ensure that patients with behavioral health disorders get identified.

6. Scope. Given the volume of patients seen in primary care settings, more generalized screening tools are ideal for detecting the wide array of mental health and substance use issues with which patients might be dealing. This consideration is particularly relevant for mental health where tools have been developed to screen for specific disorders (e.g., depression, PTSD, anxiety, etc.). With substance use, consider whether the tool screens for alcohol only, drug use only, or both alcohol and drug use.

Collectively, these criteria might appear to limit the options, yet there are many well-validated screening instruments for detecting substance use and mental health disorders with demonstrated accuracy, that are brief to administer, available free of charge, and require no clinical expertise or training to deliver. A screening process can easily be designed so that it can be conducted by an array of program staff using basic counseling and interviewing skills. Most important, there are seldom any legal or professional restraints on who can be assigned to conduct screening. Appendix B and C outlines commonly used behavioral health screening tools that meet the aforementioned selection criteria; the list provided is not exhaustive.

Adopt and Implement Clinical Protocols for Screening

Once a standardized screening instrument has been selected, protocols must be established that determine how it is going to be implemented. This will ensure that all program staff follow the same routine procedures, which in turn will enhance the likelihood that potential behavioral health issues are detected among patients.

While the depth and detail of screening protocols will depend on organizational structure and needs, the following are key elements that must be determined:

1. Which staff will be responsible for administering the screen? As indicated previously, there are seldom any legal or professional restraints on who can be trained to conduct a screening. In large part, staff resources are likely to dictate this choice. Furthermore, some of the screening tools outlined above can potentially be self-administered by the patient. Thus, programs can be creative about how best to implement screening given resource limitations.

2. At what point should the screen be administered? As a rule, screening should be implemented during the initial patient visit and repeated for subsequent visits for patients who have not indicated any behavioral health problems. Repeated administration is beneficial for two reasons. First, patients may be reluctant to divulge information about their substance use or mental health issues but may do so after establishing rapport with their physician. Second, those in recovery may be inclined to maintain their routine outside of the primary care setting but may need additional support in the event of relapse, while for others, new behavioral health problems may arise.

3. What criteria will determine a referral for assessment? Most standardized screening tools have recommended cutoff scores that can be adopted as-is or adapted to suit programmatic needs. In addition to the formal cutoff score, there may be other considerations for referral. For example, question 4 of the Modified MINI Screen relates to suicidality and questions 14 and 15 relate to PTSD and therefore a referral is recommended for positive responses.

Also, if it is the professional opinion of staff that a patient must be referred, despite not meeting criteria, clinical judgment should take precedent over protocol.

4. How will the results of the screen be documented? Answers to the screening questions and scores must be documented in the patient record in a way that flags the need for further assessment. This will help to ensure that screening is a distinct and discrete step in the process. Too often, screening tools are integrated without any intention of formally processing results.

5. What are the next steps for those who screen positive? It is important to detail exactly what is to take place after a patient screens "positive." At the very least, all positive screens will require a referral to a professional who is capable of conducting a more in-depth assessment but should also indicate what paperwork or documentation is required. Are there forms to be completed? Is there a diagnosis to be formulated and recorded?

Screening Caveats: It is Critical to Remember!!!

- *Accuracy and detection are not perfect, even with good screening tools*
- *Screens typically over-identify (e.g., produce false positives)*
- *Screens do not eliminate the need for professional clinical judgment*
- *Screens should not be used to diagnose patients*
- *Screens merely indicate that more information is required*

Comprehensive Clinical Assessment

Screening and assessment are similar in that both processes gather information about the patient to inform the provision of treatment. However, they differ in that screening is a process for evaluating the possible presence of a particular problem, while assessment is a process for defining the nature of that problem and developing specific treatment recommendations for intervention (SAMHSA, 2005). Specifically, a basic assessment consists of gathering key information as part of a process with the patient that enables the counselor to understand the patient's problem areas, disabilities, diagnoses, strengths, and readiness for change.

Typically, assessments are broadly focused and serve to organize a variety of information so that the collection of such information is done in a standard and routine way by all staff. The purpose of the assessment is to: engage the patient, identify and contact collaterals (e.g., family, friends, other providers), to gather additional information, determine quadrant and locus of responsibility, determine level of care, determine diagnosis, determine disability and functional impairment, identify strengths and supports, identify cultural and linguistic needs and supports, and determine patient readiness to change (SAMHSA, 2005).

While most assessment protocols are tailored, the following domains are often included and considered to be essential for a comprehensive clinical assessment:

1. Presenting problem including source of distress, precipitating events, associated problems or symptoms, and recent progression of symptoms.

2. Current functioning assessed by an approved functional assessment tool.

3. Current and life history exploring: age, gender and sexual identity, school and education history, employment and occupational history, abuse history (physical, psychological, sexual or emotional); legal involvement, family and relationships including natural supports, living environment, activities of daily living, and any other life domains that may emerge.

4. Family history exploring: family structure, education, employment, legal involvement, use of alcohol and/or other illicit drugs, including history of treatment; history of mental health symptoms, treatment, and medication; and strengths (supervision, involvement, stability and resources).

5. Mental status assessing: appearance, attitude and behavior; orientation to person, place, time and date; affect and mood, thought content and process (e.g., intelligence, cognition); judgment, and homicidal or suicidal risk.

6. Use of alcohol, tobacco, and/or other illicit or prescribed drugs.

7. Behavioral health medications profile for mental health and substance use.

8. Detailed history of substance use and mental health treatment, including level of care, duration of treatment, and perceived effectiveness.

9. Risky behaviors including unprotected sex and injection drug use.

10. Recovery barriers and facilitators – factors that have contributed to (i.e., what works) or inhibited (what doesn't work) previous recovery efforts.

11. Patient strengths (e.g., interpersonal, community-based, educational pursuits, spiritual or religious, and/or individual talents or interests).

12. Issues of importance identified by the patient including spiritual beliefs, cultural background, sexual orientation, housing, employment, etc.

Assessment Tools

No single standardized assessment tool for behavioral health disorders exists that can serve as the equivalent of a comprehensive clinical assessment. Select objective measurement tools that delve deeper into targeted problem areas can augment the information collected (as outlined above). Appendix B provides examples of tools that are frequently used as part of a more comprehensive assessment; each of these tools is more diverse in scope than screeners, but none address all the critical areas of assessment outlined above.

Staff to Administer Assessment

In carrying out this process, staff must understand the limitations of their licensure or certification to assess or diagnose mental health or SUDs (SAMHSA, 2005). However, collecting this type of information as part of an assessment is generally a legitimate and legal activity even for unlicensed providers, assuming that they do not use diagnostic labels when recording conclusions. To maximize the assessment process, however, it is important that designated staff is experienced in eliciting this type of information from patients. Ultimately, the choice of staff to conduct the assessment will be determined as part of the screening protocol that was recommended earlier in this article, and largely driven by the staffing resources available. Ideally, this task will be the responsibility of a licensed mental health professional (e.g., psychiatrist, clinical psychologist, nurse practitioner, licensed clinical social worker, etc.) who is able to formulate a diagnosis, and who could also seek assistance from a Certified Addictions Counselor who has expertise in issues related to addiction and recovery.

Accommodation of Behavioral Health Symptom Severity/Acuity

As was previously established, one of the primary aims of an assessment is to determine the locus and level of care necessary for each patient. A challenge for medical settings will be to accurately characterize their own level of integration and the corresponding threshold of patient acuity/severity that can be accommodated by staff onsite for substance abuse and mental health services. Ultimately, it will be necessary to determine the capacity of staff to intervene directly with the patient as well as those instances where a referral to specialty care will be required.

The Four Quadrant Clinical Integration Model

This model describes levels of integration in terms of both primary care complexity and risk and mental health/substance use risk and complexity (National Council for Community Behavioral Healthcare [NCCBH], 2003, 2004). This Four Quadrant model builds on the 1998 consensus model for mental health (MH) and substance abuse (SA) service integration by state mental health (NASMHPD) and substance abuse (NASADAD) directors. Each quadrant considers the behavioral and physical health risk and complexity of the population to suggest the major system elements to be utilized to meet the needs of the individuals within that subset of the population. To plan clinically, the population to be served must be defined. The Four Quadrant Model focuses on the populations to be served and assumes differing types of services and organizational models of integration depending on the needs of the population in each quadrant. Thus, the Four Quadrant Model is intended to be used for collaborative planning, with the Community Health Center and local provider(s) of behavioral health services using this framework to inform who will do what and how coordination will be ensured.

In some instances, patients who need comprehensive behavioral health services will require a referral to specialty care. However, for a number of reasons, there is now a strong emphasis in FQHCs on developing internal capacity to deliver MH and SUD services, as opposed to contracting out for such services. This shift is driven in part by the emergence of new integrated care models (e.g., team-based/transdisciplinary care, accountable care organizations [ACOs], and Patient Centered Medical Homes), payment reform (e.g., gain sharing incentives), accreditation requirements via National Committee for Quality Assurance (NCQA) or the Joint Commission, and to better facilitate record sharing that is problematic when providing collaborative care through interagency agreements. This new care environment inherently creates disincentives to FQHCs looking to contract services out to specialty care behavioral health providers, and substantially benefits those providers that are able to establish more integrated models of care within house.

Brief Intervention, Brief Treatment, or Referral to Treatment

Once a thorough assessment has been completed, patients can then be provided with brief intervention, brief treatment, or referral to more intensive specialty treatment depending on their level of risk. This decision can be informed in part by consulting the Four Quadrant Model system to determine risk and the most appropriate locus of care. Most patients falling within Quadrants I & III (i.e., with low behavioral health risk) can be adequately served within the primary care medical specialty systems, while those falling within Quadrants II & IV (i.e., with high behavioral health risk) should be referred to specialty behavioral health care, though the primary care physician can continue to provide medical services to the patient. In instances where behavioral health services are to be provided onsite, the Brief Intervention component of SBIRT has been conceptualized as two distinct parts that include either Brief Intervention, for those considered to be at moderate risk, or Brief Therapy, for those considered to be at higher risk (ONDCP, 2012).

Brief Intervention (BI) usually involves approximately 1 to 5 sessions, each lasting anywhere from five minutes to one hour. The goal of BI is to educate patients about their behavioral health problems and increase their motivation to reduce their risky behavior, typically by using motivational interviewing techniques. BIs are typically provided to patients with less severe alcohol or substance use problems who do not need additional services or a referral to treatment. In addition to behavioral health professionals, medical personnel (e.g., doctors, nurses, physician assistants, nurse practitioners) can conduct these interventions with only minimal training. During BI sessions, patients receive:

1. Information about their behavioral health issues based on the results of their assessment;

2. Advice on how to decrease or abstain from substance use and/or how to improve mental health functioning and symptoms;

3. Encouragement to set goals to decrease substance use, improve mental health, and to identify specific steps to reach those goals;

4. Instruction on behavior change skills that will facilitate improvement and limit negative consequences associated with behavioral health issues; and

5. Referral for care, if needed.

Brief Treatment or Therapy (BT) usually involves approximately 5 to 12 sessions, each lasting up to one hour. The goal of BT is to change not only the immediate behavior or thoughts about a risky behavior, but also to address long-standing problems with harmful drinking and drug misuse and help patients with higher levels of disorder obtain more long-term care. Much of the discussion in these more intensive brief treatments or therapies is similar to that of the BI; however, the intensive sessions tend to be longer in duration, more frequent, and can include a referral to addiction specialty care and the addition of a specific pharmacological therapy for substance use and/or psychotropic medication for mental health. While medical personnel who have received training may conduct intensive interventions, behavioral health professionals often conduct these longer counseling sessions.

Referral to Treatment

If patients report greater risk factors than what brief treatment can adequately address, they are referred to specialty substance use treatment. In some cases, a patient may receive a brief

intervention first, followed by a brief treatment before ultimately being referred to long-term care that is provided at substance use disorder and mental health treatment programs. The referral process consists of selecting appropriate treatment facilities and helping patients navigate barriers to treatment access (e.g., financial or transportation) that may prevent them from getting care.

For this process to occur smoothly, primary care providers must establish and cultivate relationships with specialty providers, and then share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the patient receives the necessary care coordination and follow-up support services is critical to the treatment process and to facilitating and maintaining recovery. The manner in which a referral to further treatment is provided can have a significant impact on whether the patient actually connects to and receives services from the provider. In this regard, the goal of SBIRT is to improve linkages between general community health care and specialized behavioral health providers to facilitate access to care when needed.

The following strategies can enhance successful treatment referrals:

1. Identify treatment options available in the community. It is imperative that staff responsible for making referrals possess extensive knowledge of behavioral health treatment services available in the community and nearby. This includes specialized substance use and mental health programs at every level of care (e.g., outpatient, partial hospitalization, inpatient, etc.) as well as mutual self-help groups for substance use (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA]), mental health (i.e., support groups are available that address a range of disorders such as depression, anxiety, bipolar, mood) and co-occurring substance use and mental health disorders (Dual Recovery Anonymous [DRA] and Double-Trouble in Recovery [DTR]).

   Information on local behavioral health services is readily available from a variety of sources. For example, SAMHSA has "treatment locators," (available online at https://findtreatment.samhsa.gov/) for both substance use and mental health services, which constitute very comprehensive searchable directories of behavioral health services by location. Resource directories are also available at the county and regional levels. Information on mutual self-help and other support group resources are also readily available through organizations such as the National Alliance on Mental Illness (NAMI) and by visiting support group sponsored websites, which include but are not limited to: AA (www.aa.org); NA (www.na.org); Cocaine Anonymous (www.ca.org); Marijuana Anonymous (www.marijuana-anonymous.org); Nicotine Anonymous (www.nicotine-anonymous.org); and DRA (www.draonline.org). Using these resources, a comprehensive list of behavioral health services can be compiled and referenced as the basis for making treatment referrals.

2. Utilize recovery services. Recovery-oriented care and recovery support systems help people with mental health disorders and/or SUDs manage their conditions successfully. Recovery is built on the individual's strengths, talents, coping abilities, resources, and inherent values. It is a holistic process that involves their community, peers, friends, and family. There are many pathways to recovery that is best determined by the individual and often involves setbacks, a natural part of life. Recovery supports that are flexible and culturally competent assist the individual in managing their illness.

   Many communities have implemented recovery support programs (i.e. peer support, mutual self-help, peer mentors, recovery coaches, peer specialists, parent support providers, youth peer support providers, and others). These supports can be located in community-based programs, behavioral health care settings, colleges and universities, and faith-based organizations, to name a few. Linking individuals with recovery resources provides for a long-term strategy; thus increasing supports necessary for mental health and sobriety as well as helping the individual address the social implications of their condition(s).

3. Formalize Partnership Agreements. FQHCs may also affiliate with community-based behavioral health providers to provide patients with comprehensive and integrated primary care and behavioral health services. Currently, this is not being done frequently, as it's often not viable financially. Instead there has been a shift toward FQHCs building internal capacity. Although the range and depth of affiliation models is beyond the scope of this paper, several approaches have been used to successfully integrate services. Though distinct in structure, each of the following affiliations are in the form of a written agreement, which is considered critical not only to demonstrate compliance with federal and state laws, regulations and guidance, but also for articulating roles and responsibilities for both partnering organizations:

Affiliation	Description
Referral Agreement	A partnership under which a provider agrees to furnish services to patients who are referred by another provider. The referring provider agrees to utilize the other provider as its preferred, although not exclusive, provider of choice for particular services. There is no change in location or purchase of services. Each party is accountable only for the services it provides to the patient on their premises.
Co-location Agreement	A partnership under which a provider agrees to treat patients who are referred to it by another provider, maintains its own practice and control over the provision of referral services, and is legally and financially responsible for the referral services. However, unlike the referral model, the provider furnishing the referral services is physically located at the referring entity's site.
Purchase of Services Agreement	In this arrangement, one provider (the purchaser) contracts with another provider (i.e., the vendor) to furnish services to the purchaser's patients, on behalf of the purchaser, who will be served at either the purchaser's facility or the vendor's facility.
Memorandum of Understanding (MOU)	An MOU is a formalized statement of the mutual expectations of two agencies. Although it is not a legally binding document, an MOU represents a signed commitment on the part of two or more parties to conduct interagency business in a specified manner. Procedurally, an MOU can specify or address the following issues: • Patient flow • Services to be provided by provider agency to patients • The types of patients most appropriate for the services • The referral process • Processes for regular meetings, phone contact, or information exchange • New, altered, or expedited procedures for patients who have been referred under the MOU • Assigning staff responsibilities • Transfer of authority to perform a mandated function

4. Practice the "warm hand-off." Making referrals with a "warm hand-off" means having the medical provider introduce the patient directly to the behavioral health provider. This should definitely be practiced in settings where behavioral health services are co-located but will require more effort in situations where a referral must be made to an outside agency / provider. In an instance where a face-to-face introduction is not possible, a conference call can be an alternative way of making this introduction. Although the warm hand-off has never been rigorously tested and there is currently no proof of its efficacy in enhancing follow-up to behavioral health treatment, it amounts to good customer service, and going that extra mile, when necessary, should improve the likelihood that patients get connected to service providers. In addition, many providers are using technology (i.e., telemedicine) to assist with the hand-off and ensure that patients are actually connected to services.

Adopting a combination of the strategies outlined above will help to ensure that medical settings implement more standardized procedures for making referrals to behavioral health treatment services, which in turn will improve consistency among staff when performing the tasks related to the referral process as well as the likelihood that patients in need of behavioral health services, in fact, receive the necessary referral(s). Furthermore, formalized written agreements help to ensure that established procedures persist between participating agencies in the event of leadership changes, staff turnover, and other organizational barriers, which are all quite common in both the behavioral health and medical service fields.

3. Team-Based Health Care and Transdisciplinary Care

During the past decade, there has been significant emphasis on the integration of behavioral health services within a variety of health care settings. The ATTC white paper, *Integrating Substance Use Disorder and Health Care Services in an Era of Health Care Reform* (ATTC Network, 2015) provides a comprehensive description of this array of models.

Despite the availability of numerous models and approaches, limited consensus has been reached as to what works best. In addition, while the ACA is clear in establishing the expectation of integrated behavioral health services, state licensing authorities generally have not crafted regulations that outline staffing provisions required to support more integrated models of care. This means that programs have minimal guidance and no clear set of expectations on best practices for integrated care, as well as limited accountability in instances of a perceived failure to provide such services.

Team-based health care has recently emerged as a promising patient-centered treatment approach that involves a whole team of health care providers (e.g., doctors, nurses, community health workers, mental health specialists, pharmacists, etc.) taking joint responsibility for the patient's care.

> *"Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care" (Mitchell et al., 2012).*

Traditionally, physicians tended to provide health care services mostly in isolation, perhaps consulting or conferring with other professionals, but largely dependent on solitary resources and their own perspective. In the past 20 years, the pace, volume, and complexity of health care has increased to the point where it is not only difficult for one individual to provide care in isolation, but also likely harmful to the patient. Conversely, incorporating multiple perspectives in health care via a team-based approach offers the benefit of diverse knowledge and experience that have the potential to improve service delivery and, in turn, patient outcomes.

Recommendation:

Establish multidisciplinary care teams that involve both medical and behavioral health staff.

Team-based care—in particular, high-performing or high-functioning teams—is now widely recognized as an essential facilitator of a more patient-centered, coordinated, and effective health care system. Reports from the Institute of Medicine (2001) and the Pew Health Professions Commission (1995) have also influenced legislative support via the ACA, as well as policy and practice development organizations (e.g., the Patient Centered Primary Care Collaborative and the Interprofessional Education Collaborative). High-functioning teams have been formed successfully in a variety of practice environments, including acute and primary care settings (Bodenheimer, 2011; Bodeheimer & Laing, 2007; Mui, 2001; Naylor, 2004; Porter & Teisberg, 2007) and to serve specific popu-

lations such as chronic care teams (Wagner et al., 2001), rapid response teams (Jones, DeVita, & Bellomo, 2011), and hospice teams (Wittenberg-Lyles & Oliver, 2007).

Although research to date has yet to establish an irrefutable evidence-base on the effectiveness and cost-effectiveness of team-based care, preliminary findings do suggest that team-based care can improve both health care quality and outcomes (Boult et al., 2009, Brown et al., 2014). Also, while common elements, success factors, and outcome measures are beginning to be described in a variety of team-based care scenarios, a widely accepted framework does not yet exist to understand, compare, teach, and implement team-based care across settings and disciplines (Mitchell et al., 2012).

Spotlight on Multidisciplinary Care Team in Action:

Dartmouth Hitchcock Medical Center Perinatal Addiction Treatment Program

The Dartmouth Hitchcock Medical Center Perinatal Addiction Treatment Program is a joint, multidisciplinary, and interprofessional venture that spans two institutions (Dartmouth Hitchcock Medical Center and the Geisel School of Medicine at Dartmouth College), three departments (Psychiatry, OB/GYN and pediatrics) and the inpatient and outpatient environments. The goal is to improve maternal and neonatal outcomes through a comprehensive program of care for pregnant and postpartum women with substance use disorders.

"At its heart, the Perinatal Addiction Treatment Program is necessarily a multidisciplinary program," says Dr. Ben Nordstrom, the director of Addiction Services at Dartmouth-Hitchcock. "There is simply no way addiction specialists can take adequate care of the obstetrical and pediatric needs of this population. By the same token, it is impossible for our colleagues in Obstetrics to meet this population's needs when it comes to mental health and addiction treatment. The only way this works is by working across departments and across institutions to draw from each other's strengths and expertise. Thankfully, our colleagues and leadership have proven to be encouraging of this multidisciplinary approach, as this is in keeping with institutional mandates to provide the best care for our patients."(D-H Today newsletter, July 2015).

SBIRT is an essential program component. PATP Director Catherine Milliken attended an SBIRT training by the NSBIRT ATTC, then set up an SBIRT training program for the multidisciplinary team. She also used the NIATx process improvement model to implement SBIRT in the Medical Center's OB-GYN Clinics. Miliken shared her experience in a series of posts on the ATTC/NIATx Service Improvement blog: http://attcniatx.blogspot.com

"Inspiring Change with SBIRT: Start with the Why"
"What Happens if They Say Yes?"
"Integrating Care and Improving Outcomes with SBIRT: An Update from the Field"
"Change, Test, Repeat: Using NIATx to Implement SBIRT"

Read them all at http://attcniatx.blogspot.com

This, and other barriers to implementation, such as recruiting and retaining qualified staff, failure of different disciplines to speak the same language, identifying and delivering training curricula that teach new evidence-based practices that are critical to behavioral health service delivery (e.g., problem solving therapy, behavioral activation) on transdisciplinary teams in community health settings, and identifying training to develop core staff competencies, has limited the explicit uptake of interprofessional team-based care.

Integrated models have now begun to develop a new conceptual model, known as **transdisciplinary care**, whereby the focus continues to be on team-based care, with all disciplines viewed as having an equally important role in the patient's care, and with each team member having expanded knowledge of the role that each discipline plays on the team (Ruddy & Rhee, 2005).

4. Evidence-Based Practices: Integrated Behavioral Health Care

Regardless of the model applied, evidence-based practices must be used to meet the goal of improving quality of care. During the past 30 years, a substantial body of rigorous study has led to the development and validation of numerous evidence-based treatments for SUDs, including a range of behavioral therapies and medication-assisted treatment for alcohol and opioid dependence. Of these research-based interventions, some are particularly well suited for use in health care settings.

Many different kinds of treatments and services are effective in helping people with SUDs. The treatment system for SUDs comprises multiple service components, including individual and group counseling, case management, medication, and recovery support services, which are provided at various levels of care (e.g., outpatient, inpatient/residential, and partial hospitalization). A person entering treatment may not need to access every one of these components, but each plays an important role. Behavioral therapies (e.g., cognitive behavioral therapy, contingency management, 12-step facilitation therapy) help engage individuals in treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt more abuse. Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat individuals with SUDs.

HealtheKnowledge: The ATTC Network's Online Learning Portal

HealtheKnowledge offers a growing list of courses for behavioral health professionals, including A Tour of Motivational Interviewing, SBIRT for Health and Behavioral Health Professionals, Foundations of SBIRT, and an Introduction to Primary care course. View the complete list at www.healtheknowledge.org

Behavioral Therapies for Substance Use Disorders

The ability to provide behavioral therapies for SUDs in primary care settings will depend on a variety of factors, perhaps none more important than the staffing structure and the existing competencies of staff.

Typically, most primary care providers are not licensed or certified to provide addiction treatment, and do not receive adequate training in the disease of addiction or the delivery of substance use treatment and associated evidence-based practices. Some primary care settings may have greater capacity for this due to the formal integration of behavioral health staff as part of the treatment team. Yet, the substance use treatment workforce may not currently be sufficient in number or have all the skills necessary to function in an integrated team environment

Ultimately, the nature of primary care treatment in terms of more limited patient contact is not conducive to delivery of more intensive forms of behavioral therapies. Instead, this will often be pursued in the specialty care system. Nevertheless, the implementation of promising practices such as SBIRT requires that staff develop skills to more effectively engage patients. Specifically, the effective implementation of SBIRT requires proficiency in Motivational Interviewing (MI).

Individuals who need to make changes in their lives approach interventions at different levels of readiness to change behavior. In fact, ambivalence about change is a normal part of the change process and if left unaddressed can be a barrier to specific behavior change. MI is an evidence-based therapeutic model that addresses ambivalence to change by evoking an individual's intrinsic motivation to change problem behaviors. When implemented in a wide range of settings, MI reduces ambivalence, improves engagement, and has demonstrated a positive effect on behavior outcomes for a variety of problem areas. MI can be defined as a method of communication designed to facilitate natural change by evoking an individual's intrinsic motivation to change

The MI approach is based on five principles:

1. Change occurs naturally.
2. Change is influenced by the interactions between people.
3. Expression of empathy is a means of effecting change.
4. The best predictor of change is confidence, on the part of all parties interacting.
5. Those who say they are motivated to change actually do change.

MI techniques can be effectively used by a variety of staff interacting with patients to achieve outcomes that are desirable for both parties with less conflict. To be effective, MI requires use of a specific set of skills, carried out in a prescribed manner. This evidence-based practice is best cultivated via training, supervised practice and feedback that is provided to staff on an ongoing basis.

BHMeds

The Mid-America ATTC has produced a smart phone app titled "BH Meds." This resource guide includes psychotherapeutic medication updates, and has been expanded to cover substance use disorder medications. This resource describes behavioral health medications, purpose, dose and frequency, possible side effects, potential for abuse and dependence, emergency conditions, and cautions (Barajas Muñoz, 2014). BH Meds is available from the App Store and Google Play. For more information, visit http://www.attcnetwork.org/regional-centers/?rc=midamerica

Medication-assisted Treatment for Substance Use Disorders

Medication-assisted treatment (MAT) refers to any treatment for a substance use disorder that includes a pharmacologic intervention as part of a comprehensive substance use treatment plan. In recent years, the Food and Drug Administration has approved new medications for the treatment of SUDs including Disulfiram (Antabuse®), Naltrexone (ReVia®, Vivitrol®, Depade®), and Acamprosate (Campral®) for the treatment of alcohol disorders; and Methadone, Naltrexone and Buprenorphine (Suboxone® and Subutex®) for the treatment of opioid use disorders. Research has found these new medications to be safe and highly effective in helping individuals achieve and sustain recovery in behavioral health and primary care settings.

As part of a comprehensive treatment program, MAT has been shown to: improve survival, increase treatment retention, decrease illicit opiate use and excessive and harmful alcohol use, decrease hepatitis and HIV seroconversion, decrease criminal activities, increase employment, and improve birth outcomes of perinatal addiction. These medications expand treatment options available to providers and should be strongly considered for use by physicians in primary care settings as a critical tool for combating substance use disorders.

5. Clinical Supervision is Critical for Supporting Implementation

Collaborative approaches such as team-based care and the implementation of evidence-based practices require routine and formal clinical supervision to ensure that staff members both develop the necessary competencies to function effectively in a multi-disciplinary team and provide effective services with fidelity to patients. That is, the comprehensive integration of behavioral health services will require continuous quality improvement efforts by leadership and other staff members occupying critical positions in this transition. Here, clinical supervision will play a key role in ensuring that newly adopted behavioral health policies, procedures, and services are implemented with fidelity by all staff.

In recent years, especially in the substance use disorder field, clinical supervision has become the cornerstone of quality improvement and assurance, bridging the classroom and the clinic. Supervision is defined as "a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices" (CSAT, 2007, p. 3).

Therefore, while clinical supervisors assume dual administrative responsibilities, the most important role of the clinical supervisor is to ensure the delivery of quality care to patients, which requires the professional development of clinical personnel. Simply put, clinical supervision is how counselors in the field learn as clinical skills are acquired through practice,

Spotlight: The ATTC Network Training Resources for Clinical Supervision

Clinical Supervision Foundations: The ATTC Network developed the Clinical Supervision Foundations course as an introduction to the essential elements of supervisory practice. In response to the need for an educational program that helps supervisors qualify for credentialing, the course presents participants with the knowledge and skills necessary to assure quality of care and promote the professional development of addictions counselors. This online course is available at www.healtheknowledge.org

Clinical Supervision Webinar Series: The Central East ATTC offers a series of webinars that highlight critical issues in establishing and sustaining a clinical supervision program. For information, visit http://attcnetwork.org/regional-centers/?rc=centraleast

Clinical Supervision I and II: These courses offered by the Northwest ATTC integrate science and the experience of master clinicians into interactive learning experiences that increase knowledge and skill. http://attcnetwork.org/regional-centers/content.aspx-?rc=northwest&content=STCUSTOM5

Technology-based Clinical Supervision: Extending the Reach of Clinical Supervisors: The National Frontier and Rural ATTC has developed a distance learning program on how to develop a clinical supervision program using communication technology tools. For more information, visit http://attcnetwork.org/national-focus-areas/content.aspx?rc=frontierrural&content=CUSTOM1SUB3

observation, feedback, and implementation of the recommendations derived from clinical supervision. As such, clinical supervision functions as a critical facilitator of behavioral health integration (CSAT, 2009).

Implementing a clinical supervision program requires a clearly articulated process. Each agency must develop a model for clinical supervision that best fits its needs and assists in reaching organizational goals and objectives. For example, there are:

1. Competency-based models (e.g., Bernard & Goodyear, 2004; Mead, 1990) focusing primarily on the skills and learning needs of the supervisee and setting specific, measurable, attainable, realistic, and timely (SMART) goals;

2. Treatment-based models that train to a particular theoretical approach to counseling, incorporating evidence-based practices (e.g., motivational interviewing, cognitive-behavioral therapy, or psychodynamic psychotherapy) into supervision and seeking fidelity and adaptation to the theoretical model;

3. Developmental models (e.g., Stoltenberg & Delworth, 1987) embracing the fact that each counselor goes through different stages of development and recognizing that movement through these stages is not linear and can be affected by changes in assignment, setting, and population served; and

4. Integrated models that include styles of leadership, articulate a model of treatment, incorporate descriptive dimensions of supervision (e.g., cultural and diversity factors) and address contextual and developmental dimensions in supervision.

Recommendation:

Develop a formal supervision structure with a routine meeting schedule that involves all members of the multidisciplinary care team.

To ensure a smooth transition to a new supervision program, an organization will need to perform these tasks (CSAT, 2007, p.7):

Define/clarify the rationale, purpose and methods for delivering clinical supervision;

Ensure that management fully understands and supports the changes that need to be made;

Provide training and support in supervisory knowledge and skill development; and

Orient clinicians to the new supervision rationale and procedures.

This is a process where changes are introduced over a period of time allowing for procedures to be developed and tested and clinicians to provide feedback and adjust to the supervisory process.

The benefits of the impact of clinical supervision on counselors working in SUD treatment programs across the United States have been well-documented. These benefits include improved self-efficacy, enhanced self-awareness, increased skill and knowledge acquisition, improved patient-provider relationships, better job performance, and increased job satisfaction (Baranik, Roling, & Eby, 2010; Knudson, Roman, & Abraham, 2013; Laschober, Eby, & Sauer, 2012; 2013; Laschober, Eby, & Kinkade, 2013; Mor Barak, Travis, Pyun & Xie, 2009; Saxby, Wilson & Newcomb, 2013).

In contrast, very few studies have examined the benefits of clinical supervision to patients, limiting the conclusions that can be drawn in this specific regard (Hoge, Migdole, Farkas, Ponce & Hunnicutt, 2011; Watkins, 2011). Nevertheless, clinical supervision constitutes good clinical practice, as it is vital for staff development and the provision of quality services in accordance with the vision and mission of the organization. The shift to integrated services in medical care settings is fundamental to improving the health and well-being of individuals.

Conclusion

The task of integrating behavioral health services within primary care and other medical settings is challenging. A number of significant clinical, operational and financial barriers impede this integration. Clinical and operational barriers include how to assimilate the core components of integration into clinical workflows. Legal issues in sharing protected health information must also be dealt with, which often will include the modification of electronic health records to accommodate behavioral health input. Also, issues of staff engagement, divided leadership, and uniting two distinctly different cultures (behavioral health and primary care) can all inhibit success. The financial barriers are arguably the most integral to success, as integration will not be sustainable if organizations cannot identify ways to pay for the services that they provide. Regardless, with the advent of the ACA, integration is the expectation and therefore organizations must identify resources and effective strategies that will better facilitate the integration of behavioral health services.

For nearly 25 years, the ATTC Network has been a resource to the field, offering a range of training and technical assistance interventions to help individual providers, programs, organizations, and systems of care to improve addiction treatment and recovery outcomes for all people who need treatment. In this era of healthcare reform, the ATTC Network continues to be a resource to the field, offering its expertise on technology transfer (i.e., the promotion of new innovations in treatment and integrated care). Early signs suggest that the integration of SUD treatment services is not receiving adequate attention in health care settings (Chaple, Sacks, Randell, & Kang, 2016; Lardiere et al., 2011; Sacks et al., 2013; SAMHSA, 2010a, b). Going forward, the ATTC Network can help to ensure that substance use disorder (SUD) treatment services are fully addressed as a part of integration efforts.

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APPENDIX A

Competencies for Integrated Behavioral Health in Primary Care

Association for Medical Education and Research in Substance Abuse (AMERSA).

AMERSA Core Knowledge, Skills, and Attitudes in SUDs for Health Professionals

Category	Competency
General Concepts	Common definitions and diagnostic criteria
	Epidemiology of substance use and related disorders
	Relationship of SUDs to family function and stability
	Risk and protective factors
Prevention	Universal, selected, and indicated prevention strategies, their effectiveness and their application at the individual, family, and community levels
	Risk and protective factors, including familial and sociocultural influences
Alcohol and Other Drug Effects	Acute and chronic health effects of substance use
	Pharmacology and behavioral effects of commonly abused substances
Evaluation and Management	Treatment approaches, including outcomes, effectiveness and costs
	Behavioral change and motivational enhancement strategies
	Relationship and interaction of SUDs and other psychiatric disorders
	Cultural context of drug use and impact of gender, culture, and ethnicity on intervention and treatment
Legal and Ethical Aspects	Confidentiality and protecting patients' rights
	Rules and regulations governing controlled substances
Health Professional Impairment	Identification, management, reporting, recovery
	Resources for health professionals impaired by substance use
Skill Competencies	Recognize early the signs and symptoms of substance use disorders
	Screen effectively for SUDs in the patient or family
	Provide prevention and motivational enhancement to assist the patient in moving toward a healthier lifestyle, or referral for further evaluation or treatment
Attitude Competencies	Approach patients in a culturally sensitive and caring manner
	Recognize SUD as a preventable, treatable condition

Source: Haack, M.R, & Adger, H. Jr., (EDs.) (2002). Strategic plan of interdisciplinary faculty development: Arming the nation's health professional workforce for a new approach to substance use disorders. Providence, RI: Association for Medical Education and Research in Substance Abuse (AMERSA).

Agency for Healthcare Research and Quality (AHRQ)

Provider-and Practice-Level Competencies for Integrated Behavioral Health in Primary Care

Category	Competency
Provider and Staff Competencies	Identification and Assessment of Behavioral Health Needs
	Treatment of Behavioral Health Needs
	Primary Care Culture; Agenda Setting, Prioritization, and Strategizing Provider Workflow
	Patient Engagement
	Whole-person Care and Cultural Competency
	Team-based Care and Collaboration
	Communication
	Professional Values and Attitudes
Practice-level Competencies	Workflow and Operations
	Administration and Leadership
	Practice Culture
	Team Structures and Roles
	Organizational Support

Source: Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Health care Research and Quality. March 2015.

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)

Core Competencies of Integrated Behavioral Health and Primary Care

Competency	Description
I. Interpersonal Communication	The ability to establish a rapport quickly and to communicate effectively.
II. Collaboration & Teamwork	The ability to function effectively as a member of an interprofessional team.
III. Screening & Assessment	The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.
IV. Care Planning and Care Coordination	The ability to create and implement integrated care plans.
V. Intervention	The ability to provide a range of brief, focused prevention, treatment, and recovery services.
VI. Cultural Competence & Adaptation	The ability to provide services that are relevant to the culture of the consumer and their family.
VII. Systems Oriented Practice	The ability to function effectively within the organizational and financial structures of the local system of healthcare.
VIII. Practice-based Learning and Quality Improvement	The ability to assess and continually improve the services delivered.
IX. Informatics	The ability to use information technology to support and improve integrated healthcare.

Source: Hoge M.A., Morris J.A., Laraia M., Pomerantz A., & Farley, T. (2014). Core Competencies for Integrated Behavioral Health and Primary Care, Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions.

APPENDIX B

Behavioral Health Screening Tools

The CAGE

The CAGE is used to test for alcohol use disorders in adults. The CAGE-AID has been adapted to include drug use (Brown & Rounds, 1995) and consists of four items that are scored as 0 for "no" and 1 for "yes." A score of 2 or more is considered clinically significant though the tool has been implemented with a cutoff score of "1." Using a cutoff score of "2" the CAGE-AID demonstrates sensitivity of 0.70 and specificity of 0.85. Using a cutoff score of "1" the CAGE-AID demonstrates sensitivity of 0.79 and specificity of 0.77. Thus, the higher cutoff score decreases sensitivity (i.e., the ability of the tool to identify "positive" patients) and increases specificity (i.e., the ability of the tool to identify "negative" patients). The CAGE-AID offers the following benefits:

Very short, the screen can be administered in less than five minutes.

The screen has good psychometric properties, based on a primary care sample, and is a useful instrument with which to initiate the conversation about alcohol or substance use with patients that may be resistant.

Because the CAGE-AID is a widely used brief screen, many clinicians are familiar with it, including those working in primary care settings.

The screen is available in English and Spanish.

The screen is available at no cost; can be downloaded online.

The Simple Screening Instrument for Substance Abuse (SSI-SA) (CSAT, 1994)

The SSI-SA consists of 16 items (14 are scored) that assess symptoms of alcohol and drug abuse during the past 6 months. Items cover problems related to lifetime and current use for respondents and lifetime use problems for family members. Items are scored as 0 for "no" and "1" for yes, so the total possible score ranges from 0 to 14. The current recommendation is that a score of "greater than or equal to 4" warrants a referral for full assessment. The SSI-SA demonstrates high sensitivity (92.6% for alcohol/drug dependence disorder and 87% for alcohol/drug abuse or dependence disorder) and excellent test-retest reliability of 0.97 (Peters, Greenbaum, Steinberg, & Carter, 2000). The SSI-SA has also been demonstrated to be a reliable substance abuse screening instrument among adolescent medical patients (Knight, Goodman, Pulerwitz, & Durant, 2000). In addition, the Modified SSI-SA is a very slightly adapted version of the SSI-SA, modified to include prescription/over-the-counter medication. These tools offer the following benefits:

The [M]SSI-SA can be administered either in the form of a clinical interview or as a self-administered test by the patient to minimize staff burden;

In either form, the [M]SSI-SA can be administered in less than 10 minutes;

The screen has excellent internal psychometrics (i.e., reliability) and very good sensitivity, specificity, and overall accuracy;

Good convergence with other substance use measures for the justice-involved;

Available in English, Spanish, Chinese, Korean, Creole, and Russian;

The screen is available to providers at no cost.

The Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screen Test (DAST)

The AUDIT (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993) and the DAST (Skinner, 1982, 2001) can be administered in tandem to screen for risky alcohol and/or substance use. The AUDIT, a 10-item questionnaire that screens for hazardous or harmful consumption, correctly classifies 95% of people as either alcoholics or non-alcoholics.

To score the AUDIT, you add up the points associated with the answer (ranges from 0 to 40); a total score of 8 or more indicates harmful drinking behavior. As an alternative, the AUDIT-C (Bush, Kivlahan, McDonnell, Fihn, & Bradley, 1998) is a 3-item version of the AUDIT that can reliably identify patients who are hazardous drinkers or have alcohol use disorders.

To score the AUDIT-C, add up the points associated with the answers (ranges from 0 to 12); for men a score of 4 or more is positive and for women a score of 3 or more is positive. The DAST-10 (Skinner, 1982, 2001) is a 10-item, yes/no self-report tool that has been condensed from the 28-item DAST. The DAST total score is the sum of the 10 items (ranges from 0 to 10) and further assessment is recommended for a score of 3 or higher. The DAST-10 correlated very highly (r=.98) with the DAST-28 and has excellent internal consistency reliability (0.92) for such a brief scale. Combining the AUDIT (or AUDIT C) and the DAST offers the following advantages:

AUDIT or AUDIT-C and DAST could be administered in less than 10 minutes;

AUDIT instruments are particularly suitable for use in primary care;

Can be administered by health professional or paraprofessionals;

Use of two instruments can distinguish between alcohol and drug problems;

Both have been used with a variety of populations and cultural groups;

Both are available free of charge.

The CRAFFT

The CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) consists of a series of 6 questions developed to screen adolescents aged 14 and older for high-risk alcohol and other drug use disorders simultaneously (Knight et al., 1999). Screening using the CRAFFT begins by asking three opening questions. If the adolescent answers "no" to all 3 opening questions, the provider only needs to ask the "Car" question. If the adolescent answers "yes" to any one of the 3 opening questions, the provider asks all six CRAFFT questions. Adolescents who report no use of alcohol or drugs and have a CRAFFT score of 0 should receive praise and encouragement. Those who report any substance use and have a CRAFFT score of 0 or 1 should be encouraged to stop and receive brief advice regarding the adverse health effects of substance use. A score of 2+ is a "positive" screen and indicates that the adolescent is at high-risk for having an alcohol or drug-use disorder and requires further assessment.

The CRAFFT has been widely validated for use with adolescents. A systematic review (Dhalia, Zumbo, & Poole, 2011) identified 11 studies on validity and six studies on reliability conducted with hospital-based clinic patients, primary care patients, emergency room patients, Native-Americans, sexually transmitted diseases clinic patients, substance users, a general population group, and enlisting military recruits. In general, the CRAFFT was found to be a good screening instrument for gradations of alcohol and substance misuse including problem use, abuse, and dependence. At optimal cut-points, sensitivities of the CRAFFT ranged from 0.61 to 1.00, and specificities ranged from 0.33 to 0.97. The CRAFFT showed modest to adequate internal consistency values ranging from 0.65 to 0.86, and high test-retest reliability. In summary, the CRAFFT has adequate psychometric properties for detecting AUD and SUD in adolescents. However, more studies of the psychometric properties of the CRAFFT need to be carried out to further assess and improve generalizability to other populations. Gender and ethnic differences also require further examination, as do versions that are adapted for different languages and cultures.

The CRAFFT

Is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents

Can be administered in less than 10 minutes;

Can be administered by a provider or self-administered by the patient. One study found that adolescents preferred filling out the CRAFFT versus having a provider ask them the questions directly (Knight et al., 2007)

Questions are available for download in 13 languages

Is available free of charge

Mental Health Screening Tools

The Modified MINI Screen (MMS)

The MMS (Alexander, Haugland, Lin, Bertollo, & McCorry, 2008) is a 22-item yes/no instrument that screens for anxiety, mood disorders, trauma exposure, Post Traumatic Stress Disorder (PTSD) and non-affective psychoses. The tool uses a set of gateway questions that relate to signs of distress that may be attributable to a diagnosable psychiatric disorder and is based in part on the DSM-IV (American Psychiatric Association [APA], 2000), the Structured Clinical Interview for Diagnosis (SCID) (Spitzer, Williams, Gibbon, & First, 1988) and the Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998).

The screen is divided into 3 sections that capture the three major categories of mental illness: Section A – mood disorders; Section B – anxiety disorders; and Section C – psychotic disorders. Scoring of the Modified MINI is straightforward and additive—each "yes" response counts as "1"; the total score will range from 1 to 22. Guidelines are not offered for a "cutoff score" and instead it is the responsibility of each program to determine, based on their patient population, the "score" that will trigger a referral. A score of 1-5 indicates a low likelihood of mental illness (further action not necessary), 6-9 indicates a moderate likelihood of mental illness (patient should seriously be considered for referral for a detailed diagnostic assessment), and 10 or higher indicates a high likelihood for mental illness (referral is necessary). In addition, question 4 relates to suicidality; any patient who answers "yes" to this question should be referred for further evaluation regardless of the total score. Also, questions 14 and 15 refer to PTSD; if both questions are answered "yes", the patient should be referred to further evaluation regardless of the patient's total score.

The following are some important advantages of the Modified MINI screen:

- The MMS can be administered and scored in 5 to10 minutes
- A manual is available to inform staff of its proper administration
- The MMS demonstrates good sensitivity, specificity and reliability
- It is available for download free of charge

The Mental Health Screening Form III (MHSF-III)

The MHSF-III (Carroll & McGinley, 2001) is a generic screening measure for a range of mental health disorders. It consists of 18 yes/no questions with all "yes" responses scored a "1" (total score ranges from 0 to 18). The first four questions are not uniquely keyed to any particular diagnosis; however, questions 5 through 17 reflect symptoms associated with the following diagnoses or diagnostic categories: schizophrenia (q5); depressive disorders (q6); PTSD (q7); phobias (q8); intermittent explosive disorders (q9); delusional disorder (q10); sexual and gender identity disorders (q11); eating disorders (q12); manic episode (q13); panic disorder (q14); obsessive-compulsive disorder (q15); pathological gambling (q16); and learning disorder/mental retardation (q17).

Psychometric properties of the MHSF-III show good internal consistency reliability and test-retest reliability (Sacks et al., 2007) as well as acceptable mean inter-item correlations, indicating that despite being correlated, items were not redundant; good item-total correlations, indicating that individual items are strongly associated with the total score of the instrument, which means that most of the items have a strong association with mental illness; and moderate endorsement frequencies. High endorsement frequencies indicate that there are items endorsed by most respondents, which can lead to an increase in inappropriate referrals, while low endorsement frequencies indicate items that are rarely endorsed by respondents, and this can lead to an increase in false-negative results (Ruiz, Peters, Sanchez, & Bates, 2009). The MHSF-III:

- Can be administered and scored in less than 15 minutes
- Can be administered by a clinician or self-administered by the patient
- Requires minimal or no training for implementation
- Available in both English and Spanish
- Available free of charge for download

The Kessler-6 (K6) and Kessler-10 (K10)

The Kessler-6 and Kessler-10 are brief mental health screening tools for use with a general adult population (Kessler et al., 2002; Kessler et al., 2003). These screens have been widely used as part of epidemiological surveys in the United States such as the National Health Interview Survey, The National Comorbidity Studies, the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, The National Survey on Drug Use and Health, and the World Health Organization's World Mental Health Initiative. Items are on a 5-point Likert scale; scores range from 6-30 (K6) and 10-50 (K10). Recommended cutoff scores are 10-13 (K6) and 19-20 (K10) for serious mental illness (SMI). Lower scores indicate more mild/moderate disorders that may require further assessment.

For the K6 and K10:

- Scales can be administered in less than 5 minutes
- Screens perform equally well across gender and cultures
- Screens are available in many languages
- Neither screening tool requires training for administration
- Versions of both screens are available for free download

Other Screening Tools

In addition to these general mental health screens, providers may consider, based on population-specific needs, whether specialized mental health screens should be administer. A detailed review of each of these tools is beyond the scope of this paper. However, the following tools are commonly used to screen for anxiety, depression, trauma, post traumatic stress disorder and bipolar disorder.

Screening Tool	Acronym	Authors
Anxiety-General Anxiety Disorder	GAD-7	Spitzer, Kroenke, Williams, & Lowe, 2006
Depression	Patient Health Questionnaire-9 (PHQ-9) or PHQ-2	Kroenke, Spitzer, & Williams, 2001
	Geriatric Depression Scale	Yesavage, et al., 1982 and its short form Lesher & Berryhill, 1994; Sheikh & Yesavage, 1986
Trauma	Life Event Checklist (LEC)	Gray, Litz, Hsu, & Lombardo, 2004; Weathers et al., 2013
Primary Care PTSD	PC-PTSD	Prins et al., 2003, 2004
	PTSD Checkllist (PCL); includes version for the military (PCL-M); civilians (PCL-C) and for specific traumatic events (PCL-S)	Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Forbes, Creamer, & Biddle, 2001; Ruggiero, Del Ben, Scotti, & Rabalais, 2003; Weathers, Litz, Herman, Huska, & Keane, 1993
Bipolar Disorder	Mood Disorder	Hirschfield et al., 2000;
	Questionnaire (MDQ)	Hirschfield, 2002; Hirschfield, Cass, Holt, & Carlson, 2005; Miller, Klugman, Berv, Rosenquist, & Ghaemi, 2004.

APPENDIX C

Assessment Tools

Addiction Severity Index (ASI)

The ASI (McLellan et al., 1992) is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to measure addiction severity as it impacts seven potential problem areas (i.e., medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status). The ASI takes one hour to administer, has been translated in 18 languages, has been adapted for use with teens (Teen-Addiction Severity Index) and for Native Americans (Addiction Severity Index North Dakota State adaptation for use with Native-Americans; ASI_ND/NAV), and is available to providers free of charge.

Global Appraisal of Individual Needs (GAIN)

The GAIN (Dennis, White, Titus, & Unsicker, 2008) is a series of measures (99 scales and subscales) that make up a biopsychosocial assessment battery designed to measure the recency, breadth, and frequency of problems, as well as service utilization related to substance use (including diagnosis and course, treatment motivation, and relapse potential), physical health, risk and protective involvement, mental health, environment, and vocational situation. The GAIN takes 1-2 hours to administer, can be completed by the patient or a clinical interviewer, has a comprehensive scoring protocol that generates a patient profile, has well established reliability, and carries a nominal licensing fee ($1) per use.

Structured Clinical Interview for DSM-5 (SCID-5)

The SCID-5 is a psychiatric interview intended to obtain diagnoses using the DSM-5 diagnostic criteria that enables the interviewer to either rule out or establish a diagnosis. Administration of the SCID-5 may take up to 2 hours. This tool focuses on present illness, past psychiatric history, substance use history, and is intended to gather enough information to formulate a tentative differential diagnosis. It is designed for use by a trained clinical evaluator at a master's or doctoral level, although in research settings it has been administered by bachelor's-level technicians with extensive training. The Research Version of the SCID-5 (SCID-5-RV) was released on November 24, 2014, for publication by the American Psychiatric Association (APA).

The Clinical Version of the SCID-5 (SCID-5-CV), an abridged and reformatted version of the SCID 5 RV, was released on November 9, 2015, for publication by the American Psychiatric Association (APA). The SCID-5-CV guides the clinician step-by-step through the DSM-5 diagnostic process covering the DSM-5 diagnoses most commonly seen in clinical settings: depressive and bipolar disorders; schizophrenia spectrum and other psychotic disorders; substance use disorders; anxiety disorders (panic disorder, agoraphobia, social anxiety disorder, generalized anxiety disorder); obsessive-compulsive disorder; posttraumatic stress disorder; attention-deficit/hyperactivity disorder; and adjustment disorder. It also screens for 17 additional DSM-5 disorders. The SCID-5-CV can be used to ensure that all of the major DSM-5 diagnoses are systematically evaluated in adults; characterize a study population in terms of current psychiatric diagnoses; and improve interviewing skills of students in the mental health professions, including psychiatry, psychology, psychiatric social work, and psychiatric nursing.

University of Rhode Island Change Assessment (URICA)

The URICA (DiClemente & Hughes, 1990) is a 32-item inventory to assess an individual's stage of change along a continuum—precontemplation, contemplation, action and maintenance. An individual's level of motivation for change and the information revealed in the URICA can be used to guide treatment options, as there are many reasons why a person may enter treatment (e.g., health concerns, court order, family ultimatums, personal reasons). The URICA takes approximately 15 minutes to administer and score, and is available to providers free of charge.

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

SOCRATES (Miller & Tonigan, 1996) is a 19-item self-report tool that breaks down readiness for change into 3 main scales: recognition (7 items), ambivalence (4 items), and taking steps (8 items). The SOCRATES takes five minutes to complete and does not require any training to administer. There are separate versions of the instrument for personal drinking and personal drug use.


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