SBIRT Implementation: The Iowa Army National Guard Program

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Contents

Exhibits

Acknowledgments

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1. Introduction

The National Guard of the United States is a reserve military force composed of National Guard military members or units of the States and territories. The National Guard's roots date back to 1636, when colonial militias made up of ordinary citizens would put down their plows and picks to pick up weapons to protect families and towns from hostile attacks (National Guard Web site, 2014). The Guard eventually grew into a combat-ready operational force that complements active-duty units when assistance is needed.

With units in communities across the country, the Guard can be mobilized for Federal active duty to supplement regular U.S. Armed Forces during times of war or emergency, and they can be activated for service in their respective States. Most National Guard soldiers and airmen hold a civilian full-time job while serving part-time as National Guard members. They serve 1 weekend per month and 2 weeks full time each year to maintain an acceptable degree of military readiness.

Today the Department of Defense has approximately 2.2 million service members in active-duty, reserve, and National Guard units (Department of Defense, 2013). The Army and Air National Guard currently provide 35–40 percent of the Army and Air Force operational force (National Guard Bureau, 2012). The National Guard's dual mission—providing trained and equipped units to the States to protect life and property and defending the Nation and its interests worldwide—makes the Guard an essential part of the Nation's defense. The versatility of the Guard enables it to respond to various scenarios, including domestic emergencies, overseas combat missions, counterdrug efforts, and reconstruction missions.

In the past, service members of the National Guard were often viewed as having a different status than other uniformed services (Part-Time-Commander.com, n.d.). In the era after 9/11, as National Guard service members have stood shoulder to shoulder with other branches of service in combat zones, regard for National Guard service members has changed. The pride of communities where service members live and work when not on active duty has been especially apparent during the wars in Iraq and Afghanistan, where large cohorts of National Guard service members have been deployed, often many times.

In the change from a strategic reserve to an operational force with planned deployment cycles, there have been significant implications for service members who may have enlisted with no overt intention of significant deployment. In the decade following September 11, 2001, 63 percent of National Guardsmen deployed to Iraq and Afghanistan once, while 37 percent deployed multiple times (O'Neil, 2012). At home, service members have worked with Homeland Security, aided at the site of the former Twin Towers in New York City, assisted in New Orleans after Hurricane Katrina, and helped in New Jersey after Hurricane Sandy.

Meanwhile, policymakers and the public at large have experienced greater awareness, commitment, and compassion related to the behavioral health of service members and their families. The Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrated its support via cooperative agreements with several States to implement screening, brief intervention, and referral to treatment (SBIRT) for unhealthy substance use by State National Guard members.

This report provides practical information supporting States and Army National Guard units that choose to implement SBIRT programs. Included here is information about military culture, the history of preventive screening in primary care, and the SBIRT model. A detailed review is provided of the Iowa Army National Guard SBIRT program's initial planning, staff roles and responsibilities, implementation, lessons learned, and suggestions for sustainability. The report also describes the unique collaboration of the Iowa Army National Guard (IANG) program and Iowa State Health Department officials. To date, the IANG SBIRT program has served more than 4,000 service members of the Iowa Army National Guard, providing evidence-based brief treatment and facilitating referrals to specialty care.

2. The National Guard

Understanding Military Culture

Understanding and assimilating successfully within the culture and practices of the National Guard is essential to the successful implementation of SBIRT. Military culture is traditionally characterized by structure, order, discipline, patriotism, loyalty, and shared values. These traits are considered essential to supporting readiness to respond to national emergency or war.

Heavy drinking is an accepted part of military culture, often used to relieve stress, provide recreation, encourage unit cohesion and build camaraderie, and reward good work (Ames, Duke, Moore, & Cunradi, 2009; Hlad, 2012). Alcohol has traditionally been a part of graduation from various levels of military training or used in rites of passage. The health hazards of alcohol abuse in the military have been well documented, and service members with substance use disorders (SUDs) may have an array of associated social and behavioral problems, such as criminal activity, violence, and loss of work productivity (Marshall, Prescott, Liberzon, Tamburrino, Calabrese, & Galea, 2012).

High rates of heavy alcohol use (Stahre, Brewer, Fonseca, & Naimi, 2009; Center for Substance Abuse Research, 2009; Bray et al., 2009) and rising rates of prescription drug use by U.S. service members have military officials concerned (Bray, Rae Olmsted, & Williams, 2012). A study by the Institute of Medicine concluded that alcohol is the military's primary concern, although prescription and other drug abuse are also considered serious problems. This study indicated the situation has reached "crisis proportions" (Weisner, 2013). SUD risk factors associated with military service include service-related injuries, trauma, separation from family, and long periods in isolated environments (IOM, 2013).

The stress of combat deployments, specifically, has been shown to result in psychological disorders, such as posttraumatic stress disorder, depression, and alcohol misuse (Jacobson et al., 2008). A U.S. Army report (2010) found that between 2003 and 2009, 29 percent of active-duty Army suicides involved alcohol or drugs, and between 2005 and 2009, 45 percent of nonfatal suicidal behaviors involved alcohol or drugs (U.S. Army, 2010). These data have serious implications since in 2012 the number of suicides eclipsed the number of military combat deaths (Rogers, 2013).

As with all U.S. military service members, National Guard troops have their own specific issues that contribute to SUDs and limit access to care, such as continual transition from active to civilian status, lack of familiarity with the Veterans Affairs (VA) system, ineligibility for some VA services, living in rural areas far from health services, and less continuity of care (IOM, 2013). Studies show that National Guard troops are more likely than their active-duty counterparts to participate in alcohol-related behaviors and less likely to enter substance abuse treatment upon

return from combat deployment (Jacobson et al., 2008; Santiago, Wilk, Milliken, Castro, Engel, & Hoge, 2010; Marshall et al., 2012).

Of particular concern for members of the National Guard is the limited access to SUD services when not on active duty (IOM, 2013). With an overburdened mental health services system that is attempting to accommodate the influx of veterans of the Afghanistan and Iraq conflicts, it is essential to innovate around identification and treatment of SUDs. The situation is so concerning that Bernard "Bernie" Sanders, U.S. Senator for Vermont and leader of a Congressional panel on mental health issues in the VA, said, "Consequences of leaving mental health conditions untreated can be dire. Such failures cannot continue" (Zaroya & Hoyer, 2013).

Military Values

Honor and integrity are core values throughout the military, and each branch of service has additional long-held traditions and defined values. The core values of the Guard include loyalty, duty, respect, selfless-service, honor, integrity, and personal courage. Additional values pervasive throughout service are self-control and fearlessness.

The Warrior Ethos

The warrior ethos[1] is essential to understanding military culture and service member dedication to duty and success. It is found in four lines of the soldier's creed (highlighted in blue at right). The warrior ethos—

- Compels soldiers to fight through all adversity, under any circumstances, to achieve victory
- Represents the U.S. soldier's loyal, tireless, and selfless commitment to his or her Nation, mission, unit, and fellow soldiers
- Captures the essence of combat and Army values
- Is sustained and developed through discipline, commitment, and pride, motivating every soldier to persevere and ultimately to refuse defeat.

The Soldier's Creed

I am an American soldier.

I am a warrior and a member of a team.

I serve the people of the United States and live the Army values.

I will always place the mission first.

I will never accept defeat.

I will never quit.

I will never leave a fallen comrade.

I am disciplined, physically and mentally tough, trained, and proficient in my warrior tasks and drills.

I always maintain my arms, my equipment, and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American soldier.

[1] Excerpted from the *The Warrior Ethos and Soldier Combat Skills* (FM 3-21.75), Department of the Army, 2008

These lines go beyond mere survival. They speak to forging victory from chaos; to overcoming fear, hunger, deprivation, and fatigue; and to accomplishing the mission.

Command Structure

Command structure is based on rank. Service members may be invited to provide input to a decision, but the final decision always rests with the senior staff member involved. Command structure influences social interactions with officers, noncommissioned officers (NCOs), and soldiers, each tending to socialize within their ranks.

Military Demographics

Sixty-six percent of enlisted service members are between the ages of 18 and 30; approximately 74.6 percent are White and 17.8 percent are African American, along with other races and ethnicities (Statistic Brain, 2013). This is roughly proportional to the general population. Within the officer ranks, racial and ethnic minorities are somewhat underrepresented and not quite proportional with the general population.

Approximately 14 percent of the Armed Forces are women (Statistic Brain, 2013). Historically, women were prohibited from certain duty classifications, particularly those that involved active combat. The wars in Iraq and Afghanistan substantially changed that, with women soldiers operating in war zones and performing duties previously carried out only by men.

Incidence of Substance Use in Military Personnel

Although illicit drug use is lower among U.S. military personnel than among civilians, heavy alcohol use and growing prescription drug misuse are on the rise (IOM, 2013). Binge alcohol use is commonplace in the comparable age cohort of young adults aged 18–24 living in the community (Bray et al., 2009). However, the rate is measurably higher for service members (47 percent) compared to civilians (22 percent) (Center for Substance Abuse Research, 2009). Many problems and consequences are associated with substance use, including suicide, acts of violence, and arrests within the community. Service members often use alcohol to cope with stress, boredom, loneliness, and the lack of other recreational activities. The easy availability of alcohol and ritualized drinking opportunities contribute to an environment that facilitates heavy and binge drinking in this population (Bray et al., 2003).

While use of other illicit substances such as marijuana, cocaine, and other stimulants is relatively low (approximately 3 percent) in comparison to alcohol use, there is growing concern about the use and misuse of prescription opioids for pain. In a recent report prepared by Bray et al. (2011), 10 percent of active-duty service members used prescription pain medications in the previous 30 days. Substance use is a priority concern for the military because of its potential effect on service member readiness, the risks posed to others, the disciplinary consequences including discharge from service, and the adverse effects on the physical and behavioral health of service members.

Army Policies Regarding Substance Use

Elements of Army policies on substance use have been viewed as barriers to service members voluntarily coming forward and seeking assistance. Concerns about the absence of confidentiality for active-duty Army members and the potential for being discharged from service have been voiced by service members and professionals implementing SUD programs. - From the Army's perspective, knowledge of a service member having an active substance use or mental health disorder is essential to determining readiness for duty.

U.S. Army Regulation 600-85 establishes policy and procedure for the Army and the Army National Guard to address substance use issues by members of the respective service. It clarifies roles and responsibilities of service members and command staff. The regulation further clarifies actions and consequences for service members who are in breach of the Army policy. It also clarifies the limits to confidentiality afforded to service members who receive treatment within the Army.

The Army Limited Use Policy (IAW AR 600-85) was initiated as a procedure to facilitate the self-identification and engagement of soldiers with SUDs in appropriate treatment or rehabilitative services. The policy prohibits the use of protected information against the soldier in disciplinary/court martial proceedings. If a commander identifies a soldier as a substance abuser through self-referral, the commander is not required to initiate separation from service action. The Limited Use Policy addresses the following:[2]

1. The Army realizes that treatment for alcohol or other drug abuse will be more effective if soldiers can admit to substance abuse without this important information being used against them. Therefore, the Limited Use Policy was developed.
2. The policy applies automatically; it cannot be given or taken away. It is intended to assist soldiers who wish to self-refer. The policy does not protect soldiers who are attempting to avoid disciplinary action.
3. Information covered by limited use includes what is disclosed to the substance abuse staff or the chain of command as part of the process of being enrolled. This includes past use of alcohol or other drugs, or past possession of drugs for personal use.
4. Limited use covers past events, not events in the future. It does not cover actions related to alcohol or drug use such as an accident while driving under the influence.
5. Administrative action is possible if the commander becomes aware of the soldier's use or abuse of drugs independently from the information provided to staff.

[2] Excerpted from http://acsap.army.mil/sso/pages/public/resources/com-faq.jsp and AR 600-85 paragraph 6-3, Army Substance Abuse Program, October 1, 2001

3. Screening, Brief Intervention, and Referral to Treatment

A Brief History of Screening for Preventive Care

Screening for preventive medical care in clinical settings is rooted in the 1930s and 1940s when public health and the concepts of disease and illness were quickly changing. Before this time, clinicians were not considered to have anything to offer healthy people. When the idea of regular medical checkups was introduced, physicians were initially skeptical, but checkups became commonplace by the 1950s and 1960s (Berg & Allan, 2001). Elvin Jellinek's work with the World Health Organization (WHO), which began in 1952, signaled a change in thinking about alcoholism. He described five types of alcohol use that included both obvious and "hidden" drinkers, which is the basis of the SBIRT screening approach (Aasland, Nygaard, & Nilsen, 2008). In the late 1980s development of good screening tools such as Cut Down, Annoyed, Guilty, Eye-Opener (CAGE) and the Drug Abuse Screening Test (DAST) made SBIRT-type screening viable (Babor, McRee, Kassebaum, Grimaldi, Ahmed, & Bray, 2007).

WHO began serious efforts toward developing and implementing screening and brief intervention initiatives in the early 1980s, convening a panel of experts that highlighted the need to develop a method to identify and curb risky alcohol consumption before it led to negative health and social outcomes (Aasland et al., 2008). This panel subsequently produced a report titled *Problems Related to Alcohol Consumption* that made the distinction between hazardous and harmful alcohol use. Encouraged by work done in Malmo, Sweden (Kristenson, Ohlin, Hulten-Nosslin, Trell, & Hood, 1983), WHO began work in 1981 on creating a simple alcohol screening tool that would be appropriate for use in both developed and developing countries (Babor et al., 2007). This work resulted in the Alcohol Use Disorders Identification Test (AUDIT), for which the first manual was published in 1989. Other work by WHO included randomized control trials in cross-cultural settings and primary care implementation with a focus on technology (Aasland et al., 2008). WHO has continued its work around screening and brief intervention.

An influential Institute of Medicine report (1990) highlighted the importance of screening in a range of health care settings to identify those with serious substance abuse problems and those with a "heterogeneous spectrum of problems that are of less than maximum severity" (IOM, 1990, p. 7). This study also recommended that higher risk patients be offered brief intervention or referral to treatment. The report puts together most of the components of the modern SBIRT model (Babor et al., 2007).

In 1993, the National Institutes of Health gave Boston Medical Center a demonstration grant to assess the feasibility of using multicultural health promotion advocates to conduct screening using a health needs history, provide brief negotiated interviews based on the readiness-to-change principles, and refer patients to treatment (Bernstein, Bernstein, & Levenson, 1997).

This emergency department initiative, led by Judith and Edward Bernstein, showed positive results in patient satisfaction, referrals to treatment, and reduction in substance use. In 1997, the initiative was implemented in seven Massachusetts hospitals and in 1998 was added as a line item to the Boston Medical Center budget. Project ASSERT (which stands for alcohol and substance abuse services, education, and referral to treatment) has since screened more than 60,000 patients, provided services to 27,101 patients, and trained more than 2,000 health care professionals (Boston University School of Public Health, n.d.).

In 2003, SAMHSA began the first large-scale implementation of SBIRT. Previous efforts had been focused specifically on research and building the SBIRT evidence base. The SAMHSA initiative was groundbreaking as it tried to effect positive change in intervention communities. The initiative started with six States and one tribal council. Since then, SAMHSA has funded 22 additional State programs through cooperative agreements with Single State Agencies (SSAs); 12 college programs; federally qualified health centers in two States (Tennessee and Virginia); 17 medical residency programs; and 14 programs that train nurses, behavioral health workers, and other health professionals who are not medical doctors (SAMHSA, 2012a).

The SBIRT Model

The SBIRT model seeks to identify and treat those who have SUDs or are at risk for developing them and to create healthier communities by reducing the health and social problems associated with SUDs. With hundreds of empirical studies on SBIRT and scores of randomized control trials on brief intervention in a variety of countries, SBIRT is recognized as an evidenced-based approach for providers (Babor et al., 2007).

Screening: As a public health approach to substance use prevention, SBIRT screening is universal. Several tools have been used, including AUDIT; the Alcohol, Smoking, Substance Involvement, Screening Test (ASSIST); CAGE; DAST; the Self-Administered Alcoholism Screening Test (known as SAAST); and the Michigan Alcoholism Screening Test (known as MAST). The screening process usually takes between 5 and 10 minutes and can be more efficient by using a prescreen of one to four questions to focus on those with potentially harmful substance use.

Brief Intervention: Patients identified with low to moderate risk levels are provided brief treatment. This typically involves one to five motivational discussion sessions that may last from 5 minutes to an hour, although in most cases 5 to 15 minutes (SAMHSA, 2011).

Brief Treatment: Patients who show moderate to severe risk are offered brief treatment sessions with the goal of developing a plan to reduce risky behaviors and substance use. Brief treatment continues motivational discussions but is typically more structured and uses advanced therapeutic approaches (e.g., cognitive behavioral therapy).

Referral to Treatment: For those at the severe end of the spectrum, SBIRT screeners generally recommend and refer patients to specialty substance abuse treatment services. In support of successful treatment referrals, it is important that providers create relationships, preferably

with signed agreements (e.g., memorandums of agreement [MOA], memorandums of understanding [MOU]), with substance abuse treatment facilities in their community. Brief interventions may also be helpful prior to referral, increasing substance abuse treatment participation and retention (SAMHSA, 2012b).

Benefits of SBIRT

SBIRT is a public health intervention that is practical for use in a variety of health care settings. First and foremost, it can identify and provide effective intervention to substance users that have not yet progressed to harmful use, addiction, and dependence. These are the majority of problem substance users with many social, behavioral, and health problems in communities across the Nation. With hundreds of empirical studies on SBIRT and scores of randomized control trials on brief intervention in variety of countries, SBIRT has been demonstrated as an evidenced-based approach for providers (Babor et al., 2007).

SBIRT can help clinicians provide prevention and intervention activities for SUDs and do so in a cost-effective way. The model is relatively inexpensive to implement in relation to the costs saved by reducing social and health problems. Many studies have shown the cost savings of SBIRT intervention. The first cost-benefit analysis of brief intervention in a managed care setting found the total benefit was approximately $5.6 for every $1 spent. The saving in the study came from reduction in emergency department and hospital use and avoidance of crime and motor vehicle accidents (Fleming, Mundt, French, Manwell, Stauffacher, & Barry, 2000).

Responsibilities for Substance Abuse Prevention and Treatment

The Federal Government requires every State and territory to designate a Single State Agency (SSA) for substance abuse to be responsible for the administration of substance abuse prevention and treatment programs. The SSA's role can include overseeing treatment centers and counselors, disseminating funding to providers, tracking statewide substance use trends, and ensuring residents receive needed services. Federal funding to plan, carry out, and evaluate substance abuse prevention and treatment-related activities is provided to the SSA primarily through the Substance Abuse Prevention and Treatment block grant (SAMHSA, n.d.).

4. The Iowa Army National Guard SBIRT Project

Introduction

The Iowa Department of Public Health (IDPH) is designated as Iowa's SSA for activities related to substance abuse. IDPH partners with local public health officials, policymakers, health care providers, businesses, and others to promote and protect Iowans' health. IDPH oversees all aspects of substance abuse prevention and treatment services throughout the State. It provides training for professionals, identifies and secures available grant funding, monitors grant compliance, and regulates licensure for treatment program.

IDPH received a SAMHSA cooperative agreement in 2012 to implement SBIRT in the Iowa Army National Guard (IANG). Strongly committed to supporting the health and behavioral health of service members from Iowa, IDPH has long considered IANG a priority since many service members lack the same access to health and behavioral health services available to members of the Army, Navy, Air Force, and Marines. IDPH values the sacrifices and services of all military members, and SBIRT further supports IDPH's commitment to Iowa's military service members. The SBIRT project provides a strong evidence-based practice to ensure all Guard personnel have access to appropriate screening, intervention, education, and referrals to treatment when needed.

In a highly innovative decision, IDPH made it a priority to establish a relationship with the Iowa National Guard command to address service member behavioral health needs. IDPH invited the Guard to participate jointly to address the shared mission of addressing substance use disorders via multiple initiatives. These included a National Women's Legislative Conference, the SAMHSA Military Policy Academy, SAMHSA's Access to Recovery program, and multiple military culture trainings and educational conferences. Building on this relationship, IANG, IDPH, and community-based substance abuse providers collaborated to address behavioral health needs within the Guard.

The Iowa Army National Guard

The Iowa National Guard, headquartered at Camp Dodge in Johnston, Iowa, is composed of IANG and the Iowa Air National Guard. Originally formed in 1838, IANG maintains 56 armories in 53 communities throughout the State. IANG has a total force of approximately 10,000 service members, and the guard units are trained and equipped as part of the U.S. Army (Iowa Army National Guard Web site, 2014). The Guard's workforce is 80 percent part time, and IANG has the second most deployed Guard during the past decade to Iraq, Kosovo, Afghanistan, Qatar, Honduras, and Kuwait.

As a matter of reference, a counterpart of IANG is the Iowa Air National Guard, considered a reserve component of the U.S. Air Force. Established in 1941, the Iowa Air National Guard units are trained and equipped by the Air Force and are subject to deployment tasking orders along with their active-duty and reserve counterparts. The Iowa Air National Guard currently consists of two major units and one support unit (approximately 1,000 service members, total) (Iowa National Guard Web site, 2014). The Air Guard, recently introduced to SBIRT, will soon begin working with SBIRT counselors to implement SBIRT in Air Guard processes.

Initially, the Iowa National Guard's Prevention, Resilience, Response, & Outreach (PRRO) Branch housed the SBIRT program. PRRO houses other public health programs (Joint Substance Abuse Prevention, Treatment, and Outreach; Suicide Prevention; Resilience; and Sexual Assault Prevention). PRRO staff include six soldiers and two civilian contractors to administer these programs to soldiers and airmen in the Army and Air National Guard units. Recently, the Iowa National Guard relocated the SBIRT program within the Iowa Army Medical Detachment (AMEDD), where other behavioral health services are situated.

Community-Based Providers

In alignment with the SAMHSA cooperative agreement, IDPH provides SAMHSA SBIRT resources to two contracted agencies to fund two full-time clinicians to conduct SBIRT services within IANG. The two community-based substance abuse treatment centers are United Community Services and House of Mercy located in Des Moines.

United Community Services is an Iowa-based, nonprofit corporation licensed by the State to provide substance abuse treatment services. Its mission is to provide quality care in a recovery-focused system, in partnership with persons served and in collaboration with the community to improve health and quality of life. Services include assessment, treatment planning, individual and group therapies, medication-assisted treatment, aftercare, and case management.

House of Mercy is a mission-based, customer-focused organization dedicated to providing health, wellness, and human services to those most at risk. Essential services include transitional and permanent housing; individual, group, and family therapy; and addiction counseling services, including relapse prevention education and therapy, aftercare support, and trauma counseling.

A full-time, State-certified alcohol and drug counselor from each of the two agencies provides SBIRT services. The two embedded clinicians are at offices at Camp Dodge near Des Moines. Many Guard activities take place on weekends, necessitating nontraditional work hours for these SBIRT staff. These staff delivers the SBIRT intervention, brief treatment, referral services, educational presentations and other services in support of the program.

Overview of the IANG Model for SBIRT Implementation

The IANG SBIRT project operates under the management of IANG, IDPH, United Community Services, and House of Mercy. In AMEDD, a lieutenant colonel and major provide supervision and direction for program implementation. The lieutenant colonel communicates directly with senior Guard leadership, including the Iowa National Guard deputy adjutant general, the Guard State surgeon general, and the State judge adjutant general (JAG). These positions played vital roles in the startup and operations of the Iowa SBIRT initiative.

The IDPH SBIRT project director serves as the designated point of contact for IANG and the contracted providers under the administrative direction of the IDPH bureau chief. The SBIRT project director collaborates with planning, program implementation, and monitoring. Client followup and evaluation activities, including collection of Government Performance and Results Act (GPRA) data are provided by an IDPH-contracted entity. A staff sergeant serves as a prevention coordinator (PC) to manage daily coordination of activities. Specific details of implementation of the SBIRT program appear in section 6 (Implementation Plan).

How SBIRT Fits Within Other National Guard Programs and Policies

At the outset of SBIRT implementation, at the request of the lieutenant colonel, the JAG conducted a review of SBIRT, including the services and benefits offered to soldiers. The JAG provided a critical review of how the program would fit within the Guard, including its relationship to existing programs and policies regarding substance use. Certain critical distinctions were made.

SBIRT screens for risk substance use, provides brief intervention to reduce risky substance use behaviors, and when indicated, offers voluntary referral assistance for further screening, assessment and potential treatment services. The SBIRT intervention does not diagnose or treat SUDs. The SBIRT procedure is categorized as level .5 of service (early intervention) within the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC) and is well beneath the Guard's allowable threshold of services, which is ASAM PPC level 2.5.

SBIRT does not replace any existing programs or services provided by IANG, especially activities used to assess readiness for duty such as random urinalysis drug testing and existing screening for substance use and abuse conducted by the Guard. SBIRT screening does not excuse a soldier from potential consequences if he or she exhibits concerning substance use behaviors such as a positive drug test or a driving-under-the-influence arrest in the community.

SBIRT augments existing efforts through the provision of an evidence-based screening and brief intervention that has been recognized and endorsed by the Department of Defense/VA clinical practice guidelines for substance abuse (VA/DoD, 2009).

Since the Guard and the IDPH are branches of State government answering to the Governor's office, IDPH can make agreements with community providers. The Guard worked with the

community providers, outlining specific responsibilities of each party in the delivery of the SBIRT program. Services defined within these agreements (provided by a designated community provider contracted and funded by the SSA) must operate within the scope of the agreement and in accordance with the SSA's standards of practice. This includes adherence to Federal laws (Code of Federal Regulations 42, Part 2; Health Insurance Portability and Accountability Act). Services delivered by Guard personnel are delivered in accordance with existing Guard policies and procedures.

The community-based agencies and their SBIRT counselors understand as part of their contracts that services are delivered within a nontraditional work schedule and at times in nontraditional settings. Travel to Guard units in other areas of the State occurs periodically.

All SBIRT-related soldier records and files are maintained in a secure file away from Camp Dodge at the United Community Service or House of Mercy. These records are stored in accordance with State and Federal laws governing patient privacy and confidentiality and operations of licensed, community, substance abuse agencies. Data are entered and stored via the Iowa Service Management and Reporting Tool (I-SMART), a Web-based software that supports substance abuse treatment information management.

Building Program Buy-In Through Champions

SBIRT champions are stakeholders and others who play a visible role in promoting and supporting SBIRT as a routine part of the Guard menu of preventive services. They are formal or informal leaders who help to integrate and normalize SBIRT into the Guard experience, and through their support during the life of the grant, they increase the likelihood of sustaining SBIRT practice after the SAMHSA funding ends. SBIRT's formal leaders are NCOs and officers, and the informal leaders are the SBIRT clinicians and service members from any rank who might have benefited from services. Champions have helped to—

- Raise awareness of SBIRT among leadership, soldiers, medical and other professionals
- Facilitate change
- Shape opinions of others, increasing buy-in and support
- Disseminate SBIRT information
- Reinforce the use of SBIRT within Guard programs
- Provide formal and informal presentations on SBIRT
- Assist in developing a supportive network
- Host SBIRT staff events
- Serve as liaison to leaders and staff
- Engage with leaders whose support plays a role in the success of SBIRT

Strategies Supporting Buy-In

An early and critical decision by IANG placed the PRRO branch chief as the lead of the SBIRT program. This established credibility and helped gain buy-in from senior Guard leadership. A full-time field grade officer, a staff sergeant (the Iowa PC), was second in command of the program. In accordance with command structure, the lieutenant colonel met first with the IANG deputy adjutant general, deputy chief of staff, and AMEDD to confirm SBIRT would be appropriately housed within the PRRO Branch. Recently, the SBIRT program was relocated to the PRRO.

The lieutenant colonel engaged the office of the JAG as previously discussed. Beyond the policy analysis and guidance, the JAG made important decisions supporting program adoption. All staff and ranking officers within IANG were instructed to participate in the SBIRT screening process as the first to be screened. These first SBIRT screening activities were successful, providing direct experience for ranking staff and helping to endorse and normalize the process. Moving forward, the lieutenant colonel, the staff sergeant (the PC), and eventually the two co-located counselors took advantage of every opportunity to train, present, and discuss SBIRT and how it could benefit IANG and its soldiers. They disseminated information about the program, including their contact information, putting a face to the program and helping to engage and integrate the co-located clinicians as part of the Guard community. The co-located staff presented with the lieutenant colonel and sergeant to help legitimize and validate the program and their roles.

The IANG team members were highly proactive in anticipating and responding to potential objections. Broad-brush orientation training and presentations at all levels of IANG helped raise awareness and understanding of the program. IANG maintained a consistent message that SBIRT ultimately benefits the health and wellness of soldiers and IANG as a whole. The timing of SBIRT was right, building on both State and national concern for soldier behavioral health.

High visibility, accessibility, sensitivity to the military culture, staff flexibility, responsiveness, and timely followup to requests further enhanced efforts. Staff worked to be attentive to the operations of the Guard and embedded services within routine operations to minimize burden and support ease of adoption. IDPH strategically and transparently used data to showcase program operations and success and published monthly reports documenting program activities and the numbers of persons served. Through these combined efforts, the team was able to make the case that the addition of SBIRT services was an improvement, with benefits at all levels of IANG.

5. Implementation Plan

Initial Planning

The use of a logic model (see exhibit 1) helped to inform and lay the groundwork for implementation, and a timeline (see exhibit 2) identified the core implementation tasks and the persons responsible for each. Initial planning occurred during the first 4 months of operations and focused on IANG leadership and IDPH confirming the MOA between the organizations; IDPH confirming agreements with the participating community-based providers; and PRRO leadership securing the support and buy-in from senior IANG command. These efforts created the platform to start implementation. An independent evaluator contracted by IDPH would conduct followup activities, including GPRA data collection. Baseline data would be collected at the time of screening, and a random sample of soldiers would participate in 6-month followup.

Startup

Startup focused on building capacity within the participating organizations to effectively implement SBIRT within a National Guard setting. Capacity building focused on building the knowledge, skills, and attitudes of the workforce to deliver responsive and effective services. This included understanding military culture (discussed earlier); working within the Guard Command Center; and developing the knowledge and skills to deliver SBIRT, including adaptations to fit within Guard programs and competency to deliver an effective evidence-based brief treatment for service members. Significant training and technical assistance resources were dedicated to build this capacity.

Staff Roles and Responsibilities

See Overview of the IANG Model for SBIRT Implementation in section 4 (The Iowa Army National Guard SBIRT Project) and exhibit 2 for staff roles and responsibilities.

Exhibit 1. IANG SBIRT Implementation Logic Model

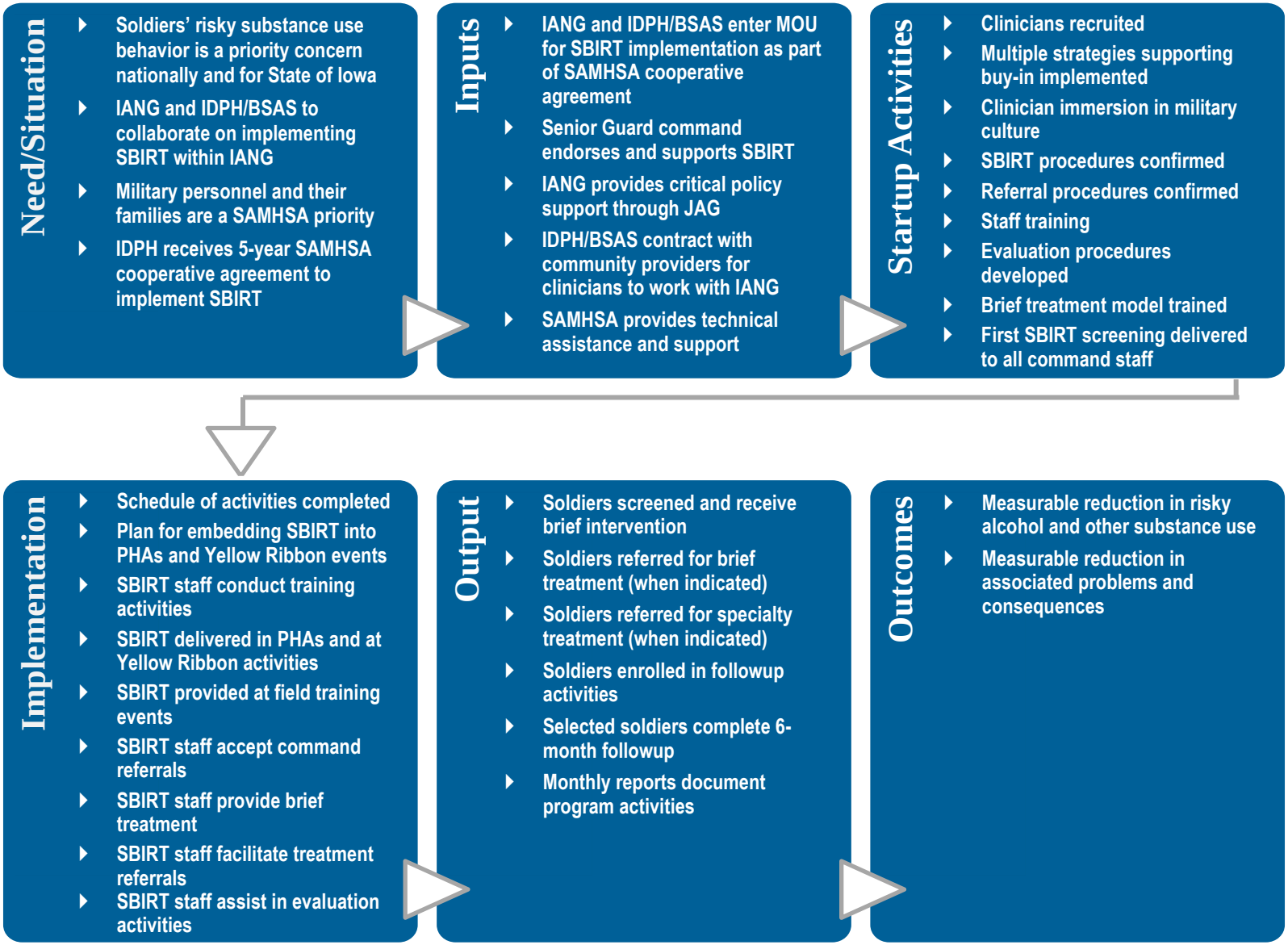


Exhibit 2. SBIRT Roles and Responsibility Timeline for Implementation of the SBIRT Program in IANG

Task	Persons Responsible	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Securing command endorsement	LTC, G1, PRRO	LTC, G1, IDPH PRRO	LTC, G1, IDPH PRRO,	LTC, G1, IDPH PRRO	LTC, G1, IDPH PRRO	LTC, G1	LTC, G1	LTC, G1	LTC, G1	LTC, G1	LTC, G1	LTC, G1	LTC, G1
Completing MOAs/contracts among IANG, IDPH, and CBOs	LTC, JAG IDPH, CBO, PRRO	LTC, JAG IDPH, CBO, PRRO	LTC, JAG IDPH, CBO, PRRO	LTC, JAG IDPH, CBO, PRRO	LTC, JAG IDPH CBO, PRRO								
Command orientation and training (SBIRT 101, electronic database)	LTC, PC, G1, PRRO, CBO, SAP	LTC, PC, G1, PRRO, CBO, SAP	LTC, PCG1, PRRO, CBO, SAP	LTC, PCG1, PRRO, CBO, SAP	LTC, PC, G1, PRRO, CBO, SAP	SAP, G1, PRRO, IDPH							
Recruit SBIRT staff/interview staff	LTC, PC, IDPH, CBO, PRRO	LTC, PC, IDPH, CBO, PRRO											
New staff complete Immersion training	PC, SAP	PC, SAP, PRRO, IDPH, CBO	PC, SAP, PRRO, IDPH, CBO	PC, SAP, PRRO, IDPH, CBO	PC, SAP, PRRO, IDPH, CBO								
Ongoing SBIRT trainings/briefings	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO	LTC, PC, SAP, IDPH, G1, PRRO
Training and technical assistance on brief treatment				PC, IDPH, SAP, G1, PRRO, CBO							PC, IDPH, SAP, G1, CBO	PC, IDPH, SAP, G1, CBO	PC, IDPH, SAP, G1, CBO
Confirm internal and external procedures			LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO	LTC, PC, SAP, G1, CBO

Task	Persons Responsible	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Screening and brief intervention with command staff				LTC, PC, SAP, IDPH, G1									
Initiate SBIRT screening within PHAs, Yellow Ribbon, and other events				LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO
Begin accepting command referrals				LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO	LTC, PC, SAP, G1, PRRO
Initiate brief treatment and referrals to specialty care				PRRO. G1, SAP,									
Initiate use of telehealth				PRRO. G1, LTC, SAP, CBO									
Policies and procedures to implement telehealth			PRRO. G1, LTC, SAP, CBO										
Review with JAG	JAG, PRRO, G1, LTC	JAG, PRRO, G1, LTC	JAG, PRRO, G1, LTC	JAG, PRRO, G1, LTC									
Obtain security clearance/badges/ background checks		JAG, PRRO, G1, LTC, SAP, CBO	JAG, PRRO, G1, LTC, SAP, CBO	JAG, PRRO, G1, LTC, SAP, CBO									

Key: CBO = Community-Based Organization; G1 = Commander in Charge for IANG; IDPH = Iowa Department of Public Health; JAG = Iowa Judge Adjutant General; LTC = Lieutenant Colonel, Commander of the PRRO; PC = Prevention Coordinator for PRRO; SAP = Substance Abuse Professional

Immersion in Military Culture

The two full-time clinicians hired began their assignments by participating in a 2-week "military culture immersion." They were oriented to military command structure, language, military rank, and working within the chain of command, order, discipline, patriotism, and military values. They also learned about the policies and procedures governing operations IANG, the PRRO branch, and the military code addressing substance use and abuse. Following this training, the clinical staff accompanied the PC and/or the lieutenant colonel (LTC) at command briefings, presentations, and other gatherings to be introduced and supported as part of the PRRO Branch.

Providing SBIRT Core Knowledge and Skills

An initial 2-day SBIRT training was provided by a consulting SBIRT subject matter expert addressing the following:

- The basics of SBIRT
- SBIRT's supporting evidence
- SBIRT's importance as a public health approach to substance abuse issues
- Prescreening using the Single-Question Alcohol Screen and DAST Single-Question Drug Screen
- Full screening for substances using AUDIT and DAST
- Skills for brief intervention, motivational interviewing, and referral to treatment
- Training in SBIRT agreement procedures, including reporting and GPRA followup
- I-SMART training

Developing a Brief Treatment Model

Supported by IDPH, IANG, SAMHSA, and SAMHSA contractor JBS International, Inc., subject matter experts developed a brief treatment model that is being used in work with soldiers. Integrated change therapy (ICT) is an evidence-based brief treatment for adults with substance use and co-occurring mental disorders. ICT integrates motivational interviewing, motivational enhancement therapy, cognitive behavioral therapy, use of medication in support of treatment and recovery (when indicated), and engagement in peer-to-peer self-help. The model is designed for delivery in a variety of settings and has been successfully used within IANG. An episode of brief treatment can range from 5 to 15 sessions plus a routine intake assessment. ICT is highly individualized, patient centered, and easily adopted within the routine workflow of an ambulatory service.

The clinicians were trained in the use of ICT, including core skills and protocols for individualizing the treatment experience. They received guides for each session, handouts and supportive materials to be used within the sessions, and information about between-session tasks that participants complete. The ICT training also provided tools that support effective intervention delivery and fidelity to the model. Following the implementation training, monthly coaching calls were conducted.

Mobilizing Resources

Through the SAMHSA SBIRT cooperative agreement, IDPH funded the two full-time clinicians described, along with administrative support, operational expenses, and dedicated resources to support specialty care beyond brief treatment. Human resources also included clinician supervision provided by the community agencies and dedicated effort from PRRO staff and the IDPH. Infrastructure support included confidential office space at IANG, printed informational materials, security screening and IANG badges to access the physical space, Internet connection, Wi-Fi cards, telecommunications, and laptop commuters.

Communication

As with any program, successful communication is essential to success. The PC and the two clinicians are housed in a small office suite within AMEDD. Communication across branches to AMEDD command and contracted behavioral health providers, Family Services, or other branches is customarily initiated through the PC or the LTC. Once the initial communication has been established, the clinicians play a role in further communication with these branches. This interbranch communication is particularly important in identifying and gathering necessary information for upcoming periodic health assessments (PHAs) or other events so the SBIRT team can plan for the events.

There are regularly scheduled meetings of clinicians and their agencies and with the LTC. The IDPH staff have regularly scheduled communication with the LTC, community providers, supervisors, and NCOs. IDPH requires written reports of performance from the community agencies regarding Guard activities and events. Particularly in the early months of program startup and implementation, more frequent communication occurred (daily to weekly), including ad hoc meetings and telephone conferences. The IDPH operates a Web-based performance and reporting systems (Iowa Service Management and Reporting Tool—the Iowa version of the national WITS Project) that enables the clinicians to upload use and GPRA data directly into this reporting system.

Methods of SBIRT Delivery Within IANG

To achieve goals for screening, brief intervention, and referral to treatment services, several distinct methods are used:

- Integrating SBIRT into the annual (mandatory) PHAs as one of the prescribed stations
- Conducting SBIRT during weekend trainings and/or other training events occurring throughout the year
- Integrating SBIRT into Yellow Ribbon Reintegration Program activities (this program provides service members, veterans, and family members with informational events and activities, referrals, and proactive outreach services throughout the phases of deployment or mobilization)
- Conducting SBIRT in response to command referrals of soldiers who have demonstrated concerning behaviors (e.g., as a result of a Serious Incident Report). Referred soldiers sign appropriate releases of information and participate in a screening and assessment with an SBIRT clinician. Findings and recommendations are shared with the identified commanding officer
- Conducting SBIRT when soldiers voluntarily self-refer and during informational and awareness-raising activities

Most SBIRT activities take place on site at Guard units, including screening, brief intervention, and brief treatment. Specialty treatment services take place in the community at an IDPH block grant-funded substance abuse treatment agency or other community provider as appropriate (e.g., community mental health center, VA hospital).

Delivering SBIRT During Periodic Health Assessments

Army Regulation 40-501, Standards of Medical Fitness, requires an annual PHA for all general officers, noncommissioned officers, warrant officers, and enlisted personnel to evaluate individual medical readiness (IMR) of soldiers. The PHA is a preventive screening strategy designed to improve monitoring and reporting of IMR for all soldiers. The PHAs occur within gatherings, and an event may screen up to 300 service members in a day. The following are PHA components:

- An overall assessment of current health and identification IMR deficiencies (if any)
- Identification of potential risk factors that could lead to diminished health
- Identification and recommendation of plans or actions to minimize potential health risks
- Recommendations for treatment of current health problems (if indicated)

Soldiers are required to check in in the PHA SBIRT screening station. If a soldier scores positive during a screening, the results are not shared with the soldier's command unless the soldier

gives written permission. Soldiers are expected to arrive and check in at the SBIRT station during the PHA, but they may decline to answer screening questions without negative consequences.

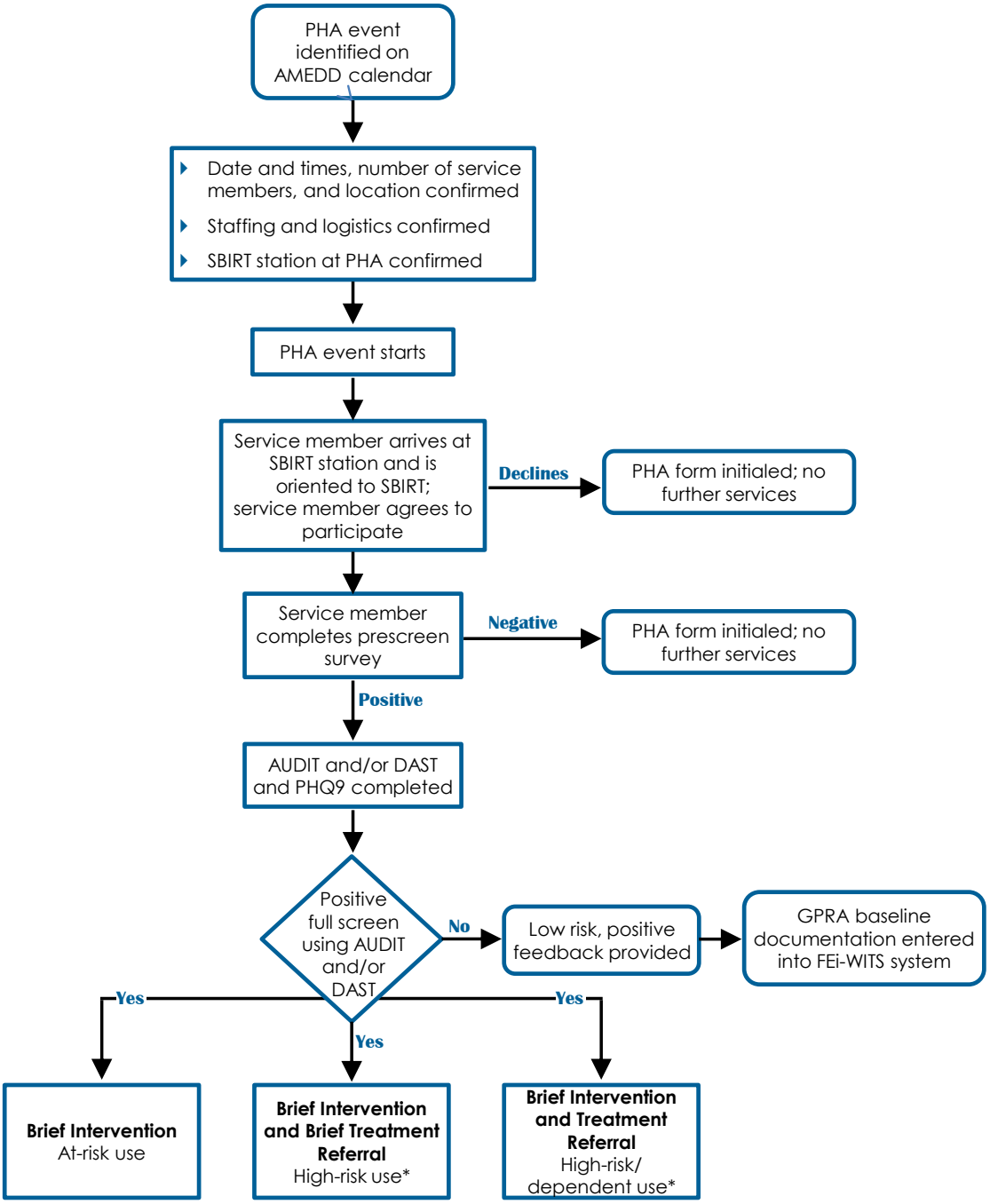
During the PHA, service members process through various screening stations (e.g., height and weight, vision, blood pressure, dental). They have a checklist for each station that is initialed by a staff member at the station, and the service members submit the fully initialed form on completion. Within this workflow, the dental station and other stations are recognized as having waiting time for completion. The SBIRT screening station is (usually) strategically placed adjacent to the dental station so that waiting service members can complete their SBIRT screening there. The SBIRT screening station is thus set up in the same manner as the other stations as part of the PHA workflow to be viewed as a normal part of the process. The decision was made to integrate the SBIRT station (rather than separate it in a more private location) to avoid negative attention to the screening.

At the PHA events, confidential interviews occur and privacy of information is afforded to service members. When the service member enters the SBIRT station, he or she is advised of confidentiality and documents voluntary consent to participate. Once the consent is provided, the service member's information is entered into the I-SMART system. Following the orientation and consent process, service members complete a prescreening process, including a single-question alcohol screen[3] and a single-question drug screen.[4] If the service member screens negative to both questions, the process is complete. If the service member screens positive to one or both, either or both of the AUDIT and DAST screens are completed. The Patient Health Questionnaire (known as PHQ-9) for depression is also completed. Without consequence, the soldier may choose to not answer questions and can end the screening at any time since participation is voluntary.

Based on the screening findings, the service member receives a brief intervention, brief intervention with voluntary referral for brief treatment, or brief intervention with voluntary referral for specialty treatment. If the service member is identified as needing further assessment and treatment, he or she is encouraged but not required to disclose this information to the commander. Brief treatment is provided by the SBIRT clinicians. For those service members accepting a voluntary referral to specialty treatment, a referral is made to a provider close to their home of record. The SBIRT clinicians remain available to service members following the PHA events. There have been instances when service members have sought out SBIRT staff after an event to request services. Exhibit 3 identifies the steps in the PHA/SBIRT planning and delivery.

[3] Recommended by the National Institute on Alcohol Abuse and Alcoholism
[4] Recommended by the National Institute on Drug Abuse

Exhibit 3. SBIRT Process in Periodic Health Assessment/Stand-Alone Event



**Service member oriented to the substance abuse Limited Use Policy and advised to disclose status with commander*
Note: Soldiers living remotely from the base are offered and can receive telehealth brief treatment via secure Web portal

Delivering SBIRT During Yellow Ribbon Reintegration Program Events and Other Stand-Alone Events

Through the Yellow Ribbon Reintegration Program, National Guard service members and their family members have access to programs, resources, referrals, and services to support and minimize stress on service members and families during all phases of deployment. The Yellow Ribbon program consists of a series of events at key stages in the deployment cycle such as—

- Phase 1: Predeployment
- Phase 2: During deployment (just for families)
- Phase 3: Demobilization
- Phase 4: Postdeployment (30, 60, and 90 days after deployment)

The Yellow Ribbon programs prepare National Guard and Reserve soldiers and their families for all phases of deployment. Commanders and leaders play a critical role in ensuring service members and their families attend events where they can access information on health care, behavioral health, education/training opportunities, employment, financial and legal benefits, marriage assessment and counseling information, VA information and enrollment assistance, education and training benefits, domestic violence awareness and prevention, substance abuse awareness, prevention and intervention, suicide awareness and prevention, and health information on traumatic brain injury, and posttraumatic stress disorder. Service providers, representing such organizations as the VA, TRICARE, Military OneSource, the National Guard Employer Support Program, the National Guard Sexual Assault Prevention and Response Program, and others, are available to provide support.

The SBIRT team has a station within a Yellow Ribbon event and can provide general information on substance use issues as well as screening, brief intervention, and referral assistance to both service members and their family members. Other stand-alone events such as annual training offer opportunities to provide SBIRT services to service members. As with PHAs, Yellow Ribbon activities occur within large gatherings of soldiers. PHAs, Yellow Ribbon activities, and other events can be conducted at any location within the State, and SBIRT staff travel to the events.

Delivering SBIRT When Responding to Command-Initiated Referrals

When a commander identifies a substance abuse problem (other than a positive drug test) and decides to counsel the service member, a referral to the SBIRT team is possible. The commander determines if the Limited Use Policy applies and seeks JAG review. The commander counsels the service member and discusses rights and options. The session is documented using DA Form 3881 (rights waiver form) and DA Form 4856 for counseling. Service member rights for legal consultation are also discussed. When the soldier agrees to seek treatment services, the commander notifies the PC, who in turn notifies the service member. The PC discusses options with the service member, including a referral to the SBIRT team or a referral to a community

provider near the service member's home of record. More frequently, service members choose the SBIRT team because of easy access.

The SBIRT team schedules an interview with the referred service member. At the outset of the interview, the clinician completes a signed release of information enabling communication with the commander or commander's designee. The SBIRT clinician does not complete the routine prescreening questions since concerning behaviors have already been identified. The complete AUDIT and DAST screens are completed, and based on levels of risk identified in the screening process, recommendations for intervention and level of care are discussed. The findings of the interview are shared with the PC and the commander. The SBIRT clinician or community provider initiates treatment, and periodic reports are made to monitor and track progress. Upon completion of treatment, the service member is cleared by the PC. The process for a soldier who self-identifies follows similar procedures except the Limited Use Policy and protections always apply.

Use of Telehealth

Soldiers living in remote areas are offered brief treatment via a secure teleconference for video and voice communication and via telephone. This is a promising new option for persons living in remote rural areas where access to face-to-face counseling could be hours away. A secure portal is available through IANG; however, issues with technology such as client hardware user bandwidth and antivirus and spyware protection have been noted and are still being addressed. Extensive policies have been written and adopted for use with this modality.

Referral to Treatment

The IDPH contracts with a network of community-based substance abuse providers that provide a continuum of services. Service members referred through SBIRT can access any of these programs, and resources are set aside to support treatment costs.

Client Perspective on IANG SBIRT and Brief Treatment

A service member who participated in the SBIRT screening process and who subsequently engaged in brief treatment agreed to be interviewed about his experiences. This officer had relapsed following many years of sobriety. In the interview, he made several important points regarding IANG SBIRT:

1. The officer believed that not just anyone can successfully operate as a clinician working in a military environment; the clinician needs to understand and accept military culture, recognize the unique stresses and challenges associated with being a service member, and be able to engage with the person being served.
2. Access is key. Having staff embedded within the command center and delivering services that are readily available to service members reduces barriers to participation.

3. The counselor's approach (brief treatment) made sense. It was individualized to address what he needed. It was flexible and not overly prescriptive.
4. Command support and approval of the program helped with acceptance by all service members.

6. Lessons Learned From SBIRT Implementation

General Lessons Learned and Best Practices From the Field

SBIRT is best implemented as a team effort. Staff of all levels, regardless of the institution, should be involved in providing input for decisionmaking around model development, financing, sustainability, monitoring, and evaluation. The core SBIRT implementation team is most effective when made up of people with a diverse range of skills and experience. It is important to develop and communicate clear roles and responsibilities based on staff strengths, interests, and skills.

A clear and practical implementation plan is essential. This includes management structures, clearly defined partner roles, protocols for program operation (e.g., telehealth, common sets of tools), ongoing training and capacity building, and a system for regular communication with community partners. Building strong yet flexible structures and processes helps facilitate accountability, smooth workflows, sustainability, lasting partnerships, and improved program outcomes.

To secure buy-in from stakeholders, it is important to educate as many people as possible about SBIRT. Putting SBIRT into routine health care is a cultural shift in most implementation sites. While clinical project staff will have more indepth training, other people working at an SBIRT site should also understand the basics of SBIRT and how they can help the effort succeed. This includes everyone from clinic managers to physicians and receptionists. A successful SBIRT program also depends on connections with the health care and social services sectors. SBIRT materials must be widely disseminated in the community, especially in substance abuse treatment facilities.

SBIRT is flexible and adapts to many settings, from emergency departments to dentists' offices. While there is an SBIRT implementation guide for those awarded SAMSHA grants to implement SBIRT, each new setting has a unique population, staff, policies, and procedures. SAMHSA grants are not research focused and therefore do not require strict research protocols. Service and training grants can be continuously adapted to meet local needs. It is important that grantees take advantage of this flexibility and modify their programs throughout the life of the grant.

Accurately recording, storing, and disseminating data will help implementers make evidence-based modifications to their programs. SBIRT implementers are encouraged to develop a rigorous monitoring and evaluation plan that uses trackable indicators and involves people at all levels in process improvement. Showing positive data can also assist SBIRT programs secure

additional funding and support from decisionmakers. A creative marketing approach can use the data to highlight program successes (SAMHSA, 2011).

Most programs integrate SBIRT into already existing processes and make it part of routine health care, similar to taking blood pressure or temperature. This helps to normalize the activity, and patients are more likely to accept it as part of the routine.

Specific Lessons Learned From Implementation of SBIRT in the Iowa Army National Guard

The following are important factors contributing to the success of SBIRT implementation at IANG:

1. Collaboration among the National Guard, the State substance abuse authority, and community behavioral health providers
    - The collaboration among the three entities is essential for success. Each brings necessary skills and resources to the process with a commonly shared mission of improving the behavioral health and readiness of Iowa's "citizen soldiers."
2. Approval, endorsement, and support from senior National Guard command
    - The National Guard operates within a clearly defined chain of command. Seeking and receiving the endorsement from senior command was a necessary first step in program implementation.
3. Immersion of staff in military and National Guard culture
    - The immersion in military culture was an important element of clinician preparation for work within the Guard and the success of SBIRT in this setting. The increased understanding of and appreciation for the unique culture and context of the Guard enabled success working within that system and competence to engage and work successfully with service members.
4. Engaging command staff in the clinician selection process
    - PRRO staff actively participated in the selection of the SBIRT clinicians. This helped ensure the "right fit" of the clinician for the assignment. Although neither clinician had prior work experience in military settings, both were experienced in working with special populations and in nontraditional work settings. These prior work experiences contributed to a heightened awareness of context and culture of the work environment. A clinician familiar and comfortable only with a standard office practice of scheduled appointments and 50-minute hours might have challenges adapting to a work environment that involves flexible schedules and a wider range of skills.

5. Building buy-in and exposure at all levels of the system
    - Following senior command endorsement, actively orienting all levels of the Guard personnel to SBIRT helped to build awareness, acceptance, and buy-in. Having command staff be the first service members to experience the SBIRT screening and brief intervention sent an important message to all service members, endorsing and normalizing the process.
6. Assimilating SBIRT into existing practices
    - Embedding SBIRT in the PHA and other routine activities required few changes to existing processes and further helped normalize the activities as routine.
7. Assuring of privacy of information
    - Providing confidentiality of information to service members participating in the SBIRT screening process is an important enhancement addressing service member concerns that the information might otherwise have a negative impact on their career within the Guard. It is likely that some service members remain mistrustful of this assurance, particularly insofar as illicit substances are concerned. The level of self-reported risky alcohol use consistent with a young adult population suggests increased candor when discussing alcohol use.
8. Reducing barriers to services
    - Co-locating clinicians on site at the Command Center has made services more readily accessible to service members and command staff. The active advocacy and support by IDPH for accessing specialty care has minimized financial and other barriers. The use of telehealth strategies has increased access to SBIRT services for members living in rural areas.
9. Communication
    - Regular and ad hoc communication among all the collaborators has been essential to adjust plans as needed, clarify roles, mobilize resources, and support the ongoing flow of necessary information.
10. Training, technical assistance, monitoring, and support
    - It is important to train and orient everyone involved. As part of this training, it is important to answer the often unspoken questions of why this? Why now? Why us? Direct service staff need training, coaching, and monitoring to help build proficiency, support their implementation and adoption of new practices, and problem solve implementation challenges. Despite even the most carefully thought-through implementation plan, “Something new is never done 100 percent right the first time.”

7. Considerations for Sustainability

Although SBIRT is relatively new within IANG, constructing strategies early to support sustainability has increased the likelihood of long-term success. Sustainability strategies include the following:

1. Maintain a successful and flexible working relationship between IDPH and IANG.
2. Each branch of government brings unique assets and capacities to bear on the commonly shared concern and common mission for service member behavioral health. Through IDPH, resources to support SBIRT staffing and a continuum of treatment can be accessed with greater flexibility in delivery. The National Guard has responsibility for service member readiness and routinely conducts events such as the PHA, Yellow Ribbon, and other activities where universal service member (and family) screening can occur.
3. Through its role as the State substance abuse authority, IDPH has access to a wider range of resources to support SBIRT services.
4. Make the case to internal and external stakeholders. SBIRT has multiple levels of value for service members in the Guard. Use of data is important to demonstrate the impact of the program and how the program is an improvement over historic practices. The data can also showcase strengths and accomplishments. However, use of data alone is usually not enough. The broader human and organizational value and story must be told.
5. Demonstrate how success breeds success. A successful program implementation has the support of key stakeholders and provides a vision to others about what is worth sustaining.
6. The SBIRT program is a concrete action aligned with service member public policy and public sentiment. Aligning the program and its accomplishments with public policy and sentiment supporting improved services broadens the base of potential public support.
7. Maintain an ongoing strategy of communication with internal and external stakeholders. Communication strategies can educate, inform, and mobilize policymakers and funders.
8. Develop a written sustainability plan.

8. Abbreviations and Acronyms

AMEDD	Army Medical Detachment
ASAM PPC	American Society of Addiction Medicine's Patient Placement Criteria
ASSIST	Alcohol, Smoking, Substance Involvement, Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CAGE	Cut Down, Annoyed, Guilty, Eye-Opener
DAST	Drug Abuse Screening Test
GPRA	Government Performance and Results Act
IANG	Iowa Army National Guard
ICT	Integrated change therapy
IDPH	Iowa Department of Public Health
I-SMART	Iowa Service Management and Reporting Tool
IMR	Individual medical readiness
LTC	Lieutenant colonel
PC	Prevention coordinator
PHA	Periodic health assessment
PHQ-9	Patient Health Questionnaire (for depression)
NCO	Noncommissioned officer
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, brief intervention, and referral to treatment
SSA	Single State agency
SUD	Substance use disorder
VA	Veterans Affairs
WHO	World Health Organization

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