SBIRT IOWA

Screening, Brief Intervention, and Referral to Treatment

THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Year One

Annual Evaluation Report

August 2013

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Year One Annual Evaluation Report

August 2013

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http://iconsortium.subst-abuse.uiowa.edu/

EXECUTIVE SUMMARY

In July 2012, the Iowa Department of Public Health (IDPH) was awarded a five year grant to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) services by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). SBIRT IOWA uses a comprehensive, integrated, public health approach to incorporate universal screening into medical practice and within the Iowa National Guard to identify, reduce, and help prevent risky alcohol or drug use, abuse, and dependence on alcohol and drugs. During Year One, SBIRT programs were implemented at four Federally Qualified Health Centers (FQHC's) in Blackhawk, Polk, Scott, and Woodbury counties of Iowa as well as at Camp Dodge, home of Iowa's National Guard. Co-located substance abuse professionals work with each site. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the SBIRT project. Results of the Year One evaluation help demonstrate the important health benefits SBIRT IOWA provides adults in Iowa.

Iowa residents age 18 and older are prescreened utilizing two questions about alcohol use and illegal drug or prescription misuse. Individuals receive full screening if they indicate any of the following occurring within the past year:

- Men up to age 65 report drinking over four drinks on one day or over 14 drinks in one week.
- Women of any age and men over age 65 report drinking over two drinks on one day or over seven drinks in one week.
- Any illegal drug use or prescription use for non-medical reasons by men or women of any age.

Two instruments are used by SBIRT IOWA to conduct full screenings. The AUDIT is administered to individuals to screen for risky drinking and alcohol use disorders. The DAST-10 is used to identify risk for abuse of illegal drugs and prescription drugs misuse. The following table provides the recommended service associated with how an individual scores on the screening instrument(s).

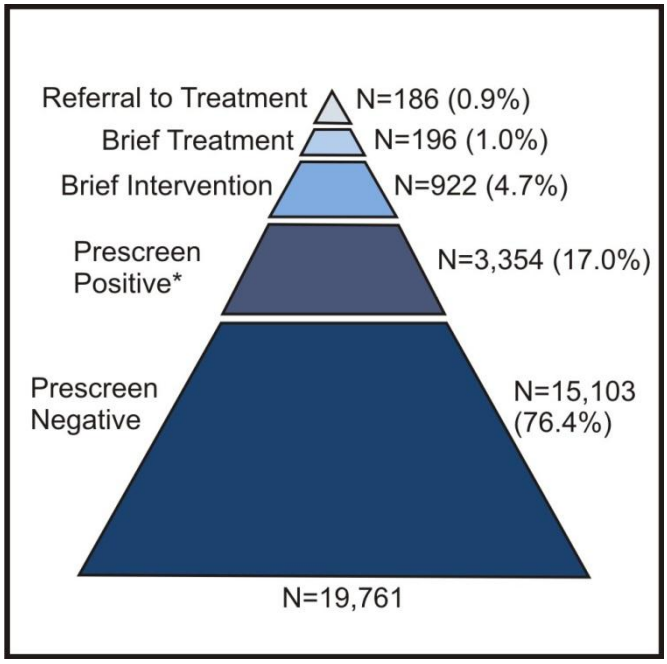
Recommended Services Based on Full Screening Scores				
AUDIT		**DAST-10**		**Recommended Service Modality**
Score	Risk Level	Score	Risk Level	
0 - 7	Low Risk/Negative	0	Low Risk	Screening: Encouragement and Education
8 - 15	Risky or Hazardous	1 - 2	Moderate Risk	Brief Intervention
16 - 19	High Risk or Harmful	3 - 5	Substantial Risk	Brief Treatment
20 - 40	High Risk	6 - 10	Severe Risk	Referral to Treatment

In addition to the screening instruments, SBIRT staff are required under the Government Performance and Results Act (GPRA) to gather demographic information. Depending on screening scores, additional GPRA data are collected from individuals who screen positive for risky alcohol or drug use, including past 30 day substance use and other factors related to health.

SBIRT services began being offered to individuals in Iowa in late October 2012. During Year One of SBIRT IOWA, staff made an effort to screen as many individuals as possible. Prescreening for alcohol and illegal drug use were provided to nearly 20,000 individuals, full screenings were administered to over 4,000 people. During the initial eight+ months of the project, each month on average nearly 2,500 individuals were prescreened and over 500 received full screening.

Individuals receiving prescreening ranged from 18 to 99 years of age with a median age of 43 years. Approximately 58% of the individuals were female and 42% were male. The highest numbers of males and females were between 45 and 54 years of age and in all age categories, there were more females than males. Of those receiving prescreening, 78% reported their race as White and nearly 16% identified as African American; individuals reporting other races accounted for less than 5%. Nearly 14% of those receiving prescreening indicated they were of Hispanic or Latino ethnicity.

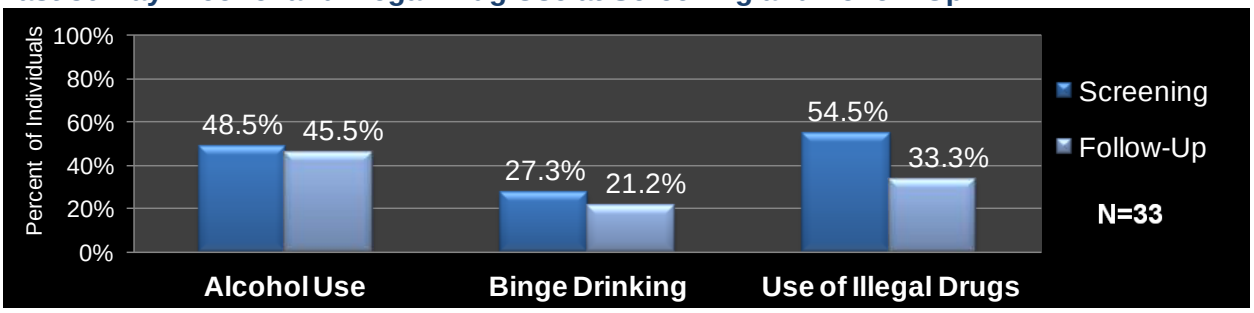
Nearly 24% of the individuals prescreened positive for potential of some level of risky alcohol or use of illegal drugs in the past year. Many of these individuals went on to complete a full screen utilizing the AUDIT and/or DAST-10. Most were identified as low risk and provided encouragement and education. Of the 19,761 individuals receiving prescreening in Year One, nearly 5% were recommended for Brief Intervention, 1% were recommended for Brief Treatment and approximately 1% were offered a Referral to Treatment.



*Individuals who prescreen positive and full screen identifies as low risk.

A random 10% sample of individuals assigned to the Brief Intervention, Brief Treatment, and Referral to Treatment modalities are selected to complete follow-up interviews which occur approximately six months following screening. As displayed in the following figure, 33 individuals completed a follow-up interview during Year One. At screening, 16 of the individuals (48.5%) reported alcohol use in the past 30 days, nine (27.3%) reported binge drinking (five or more drinks in one sitting), and 18 (54.5%) reported illegal drug use in the past 30 days. At follow-up, 15 individuals (45.5%) indicated alcohol use in the previous 30 days with seven (21.2%) reporting binge drinking; 11 individuals (33.3%) reported the use of illegal drugs in the 30 day period prior to the follow-up interview.

Past 30 Day Alcohol and Illegal Drug Use at Screening and Follow-Up



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BACKGROUND

In July 2012, the Iowa Department of Public Health (IDPH), Division of Behavioral Health was awarded a five year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. SBIRT IOWA is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. During Year One, SBIRT programs were implemented at four Federally Qualified Health Centers (FQHC's) in Blackhawk, Polk, Scott, and Woodbury counties as well as at Camp Dodge, home of Iowa's National Guard. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the SBIRT project.

The SBIRT IOWA project makes it possible for trained staff to administer prescreening and screening for alcohol and substance use, as well as conduct Brief Interventions, Brief Treatment sessions, and make referrals for substance abuse treatment. Individuals age 18 and over receiving medical services at the FQHCs and soldiers affiliated with the Iowa National Guard are receiving SBIRT services. This report presents results of the evaluation conducted for Year One of SBIRT IOWA and includes data through June 30, 2013. Due to rounding, percentages in this report may not add up to exactly 100%.

Implementation

Immediately upon grant award notification, staff at IDPH initiated an intensive planning and implementation process including meetings, dissemination of information, phone conferences, training sessions, and webinars. IDPH utilized a phased rollout with the five sites involved in the SBIRT project during Year One; service delivery in Iowa began within four months of the grant award. Substance abuse professionals are co-located at the four FQHCs and with the National Guard. Table 1 provides the location, the service provider, the substance abuse treatment agency working in coordination with the service provider, and the date sites began conducting SBIRT services.

Table 1. Service Providers and SBIRT Start Dates

County	Service Provider	Substance Abuse Treatment Agency	Date SBIRT Services Began
Scott	Community Health Care, Inc.	Center for Alcohol & Drug Services, Inc.	10/25/12
Statewide	Iowa National Guard	House of Mercy and United Community Services	11/03/12
Woodbury	Siouxland Community Health Center	Jackson Recovery Centers	11/14/12
Blackhawk	Peoples Community Health Clinic	Pathways Behavioral Services	11/15/12
Polk	Primary Health Care, Inc.	MECCA Services	11/27/12

Iowa National Guard

Implementing SBIRT services within the Iowa National Guard was a unique situation. As the Iowa National Guard made implementation plans, their first goal was to attempt to maintain a similar approach as that of the SBIRT model used in primary health care settings. The National Guard spent a significant amount of time educating the two substance abuse treatment counselors who would be providing SBIRT services with soldiers; this included providing in depth detail on the military culture, education on the ranking structure, attending briefings, and other relevant education to ensure quality SBIRT care would be provided to service members.

The Iowa National Guard provides SBIRT services in several ways including:

1. SBIRT services are incorporated into the annual Periodic Health Assessments (PHA) soldiers receive through the National Guard.
2. Soldiers are referred for SBIRT services when they receive a Serious Incident Report (SIR) after an alcohol or drug incident; for example, when a soldier tests positive for illicit drug use during routine drug screening.
3. When a Commander feels a soldier may have an alcohol or drug related issue.

One major accomplishment of implementing SBIRT services within the National Guard is the ability to offer Brief Treatment services to service members via webcam utilizing the Defense Connect Online system and to conduct distant treatment over the telephone. This provides accessibility to services for soldiers located across the state of Iowa, including those who live in rural areas; this also reduces the stigma associated with receiving substance abuse services. More detailed information is provided in the Focus Group section of this report regarding SBIRT services in the Iowa National Guard.

PROCESS

Prescreening and Screening

SBIRT staff at FQHCs and the Iowa National Guard administer the prescreen consisting of two questions:

1. *How many times in the past year have you had:*
   If male up to age 65: *over four drinks on one day or over 14 drinks in one week?*
   If female of any age or if male over age 65: *over two drinks on one day or over seven drinks in one week?*

2. *How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?*

Individuals prescreen positive by answering 'one or more' to either question and should receive additional screening (referred to as "full screening") to assess the severity of substance use and help identify the appropriate level of services needed based on the individual's risk level. The two full screening instruments used are the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST-10). The AUDIT is administered when an individual prescreens positive for the alcohol question and the DAST-10 is administered when an

individual prescreens positive for the drug question. If the individual prescreens positive on both questions, both the AUDIT and DAST-10 are given. The full screening instrument answers are scored on a point system. Table 2 shows the recommended services based on the score ranges. It is important to note that staff are allowed to use clinical judgment when offering services to individuals, regardless of the scores.

Table 2. AUDIT and DAST-10

Score	Risk Level	Recommended Service
AUDIT		
0 – 7	Low Risk/Negative	Encouragement and Education*
8 – 15	Risky or Hazardous	Brief Intervention
16 – 19	High Risk or Harmful	Brief Treatment
20 – 40	High Risk	Referral to Treatment
DAST-10		
0	Low Risk	Encouragement and Education*
1 – 2	Moderate Risk	Brief Intervention
3 – 5	Substantial Risk	Brief Treatment
6 – 10	Severe Risk	Referral to Treatment

*Modality selection by SBIRT staff should be 'Screening'.

Individuals who screen as low risk are provided positive feedback, encouragement, and education; the corresponding SBIRT modality is Screening. Brief Intervention is recommended for individuals who score in the next range and focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Brief Treatment is offered to individuals scoring in the next range and usually consists of five to twelve sessions to change not only the immediate behavior or thoughts, but also address long-standing problems with harmful drinking and/or drug misuse. Individuals who screen at the highest level are identified as needing a referral to treatment, which provides specialized substance abuse treatment.

In accordance with SAMHSA funding requirements, SBIRT staff collect data for the Government Performance and Results Act (GPRA). The modality (level of service) recommended to an individual is based on the results of the prescreening and full screen instruments. Table 3 provides GPRA requirements at prescreening and screening based on the individual's recommended modality.

Table 3. GPRA Requirements

	Prescreening Only	Screening Only	Brief Intervention	Brief Treatment	Referral to Treatment
GPRA Section(s) to be Completed	Section A	Section A	Sections A – B	Sections A – G	Sections A – G

When an individual prescreens positive and the AUDIT and/or DAST-10 are administered, in accordance with GPRA requirements, SBIRT staff record the individual's score and results for GPRA question 2a:

How did the client screen for your SBIRT? Negative or Positive

Results from 19,761 GPRA records from Year One of SBIRT IOWA indicate 1,963 (9.9%) participants screened positive and 17,797 individuals (90.1%) screened negative.

As analyses were conducted on positive and negative responses for this question by modality selected, potential discrepancies were identified indicating project staff may not be entering data consistently for GPRA question 2a. The SBIRT IOWA Project Director contacted SAMHSA to obtain the correct coding instruction*: The response for question 2a should reflect results from the full screen (AUDIT/DAST-10) and not the two question prescreening. Score negative if negative on the full screen and score positive if positive on full screen (AUDIT/DAST-10).* The Project Director recently alerted staff at all sites; efforts are in place to remedy this situation. Therefore, analyses in this report exclude this variable. Due to these issues and upon instruction from the SBIRT IOWA Project Director, when possible in this report, records with the presence of AUDIT and/or DAST-10 scores of greater than zero are considered to be positive prescreens.

INDIVIDUALS SERVED IN YEAR ONE

There were 19,761 records for individuals receiving SBIRT prescreening in Year One of SBIRT IOWA. Utilizing the method described in the previous section of considering positive prescreens based on the presence of AUDIT and/or DAST-10 scores greater than zero, 4,390 (22.2%) of the individuals prescreened positive for alcohol and/or illegal drug use and received full screening with the AUDIT and/or DAST-10. An additional 268 records contain AUDIT and/or DAST-10 scores of zero and are considered to be individuals who prescreened positive, but did not complete full screening. Table 4 presents information on positive prescreen records and full screens conducted.

Table 4. Positive Prescreens

Screening Instrument	Total Records	Records With Scores of Zero	Number of Full Screens Conducted
AUDIT Only	3,695	211	3,484
DAST-10 Only	410	31	379
Both AUDIT and DAST-10	553	26 (score of zero for both screens)	527
Total	4,658	268	4,390

For individuals completing a full screen, the modality entered by SBIRT staff should reflect the recommended service corresponding with the AUDIT and/or DAST-10 score, regardless of what services were offered to the individual. The SBIRT IOWA Project Director has instructed staff to document when a different level of service was offered and accepted by the individual. Table 5 presents the number of individuals served in SBIRT IOWA by modality selected by SBIRT staff

in Year One. Analyses revealed some discrepancies; the modality selected may not always represent the service based on AUDIT and DAST-10 score recommendations: 147 records assigned to the screening modality have AUDIT scores of eight or higher and 215 records recorded as screening have DAST-10 scores greater than zero. Therefore, it is important to note that information in Table 5 reflects modality recorded by staff at prescreening and screening and does not reflect score(s) from the full screening instruments.

Table 5. Individuals Served by Modality

SBIRT IOWA	
Modalities	Services Provided in Year One % (N)
Prescreening Only	76.4 (15,103)
Screening and Feedback	15.6 (3,086)*
Positive Prescreen, Full Screen Not Completed	1.4 (268)**
Brief Intervention	4.7 (922)
Brief Treatment	1.0 (196)
Referral to Treatment	0.9 (186)
Total Individuals Served	19,761

*Excludes records with AUDIT and/or DAST-10 scores of zero.
**Individuals with presence of an AUDIT and/or DAST-10 date and scores of zero.

Figure 1 on the following page displays the number of prescreens and screens by month in Year One of SBIRT IOWA. The number of individuals receiving full screening includes all records with the presence of AUDIT and/or DAST-10 scores greater than zero. Excluding October 2012 (since prescreening began at the end of the month), on average each month, 2,459 individuals received prescreening in Year One and 545 people received a full screen.

Figure 1. Prescreens and Screens by Month

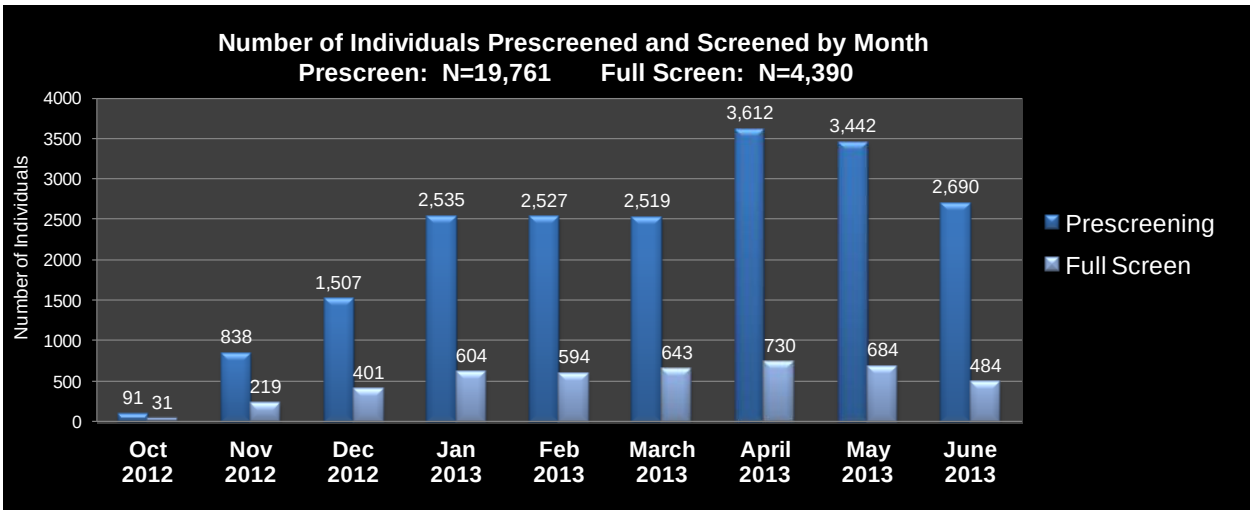


Table 6 provides the annual targets set by SAMHSA for SBIRT IOWA (according to the SAIS system) for the number of individuals to be prescreened, completing full screening, and in each modality.

Table 6. Goals in Year One

SBIRT Modality	Year One SAMHSA Target	SBIRT IOWA Year One Services	Year One Rate
Total Individuals Served	16,905	19,761	116.9%
Screening	8,898	18,457	207.4%
Brief Intervention	6,227	922	14.8%
Brief Treatment	890	196	22.0%
Referral to Treatment	890	186	20.9%

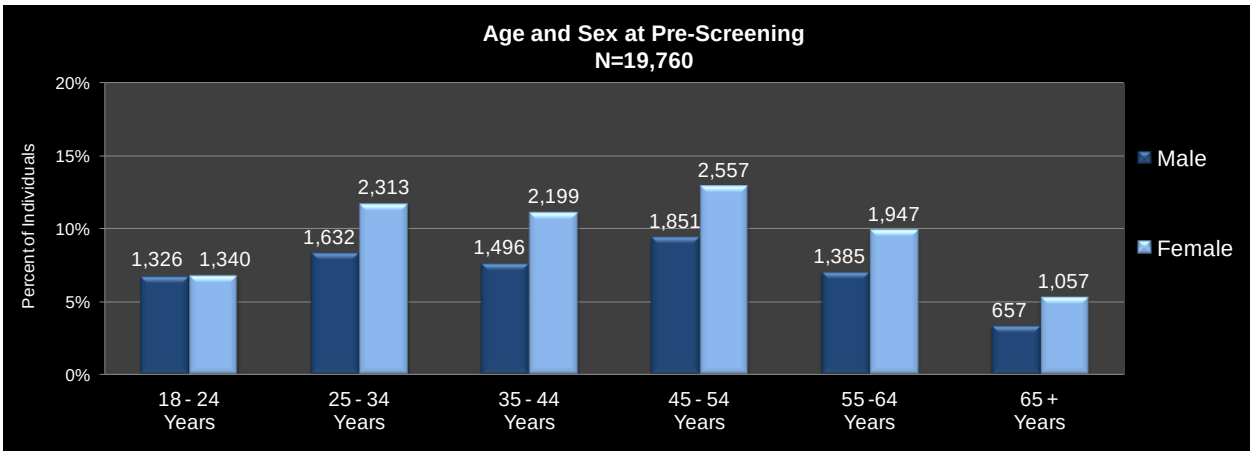
DESCRIPTION OF INDIVIDUALS RECEIVING PRESCREENING

Description of Individuals at Prescreening

There are 19,761 SBIRT IOWA records in Year One. Individuals who were prescreened ranged from 18 to 99 years of age with a median age of 43 years; ages are approximate since the GPRA instrument collects month and year of birth. Eight thousand three hundred forty-seven participants (42.2%) were male and 11,413 participants (57.8%) were female.

Figure 2 presents the number of males and females in six age categories. The highest numbers of males and females at admission were between 45 and 54 years of age. For all age categories, there were more females than males.

Figure 2. Age and Sex



Note: Data for one individual are not included due to data issues resulting in inability to determine age.

Table 7 on the following page presents race and ethnicity reported at prescreening. The majority of individuals (78%) receiving SBIRT IOWA services in Year One were white, nearly 16% were African American, and the remaining 6% reported other races or more than one race. The project served nearly 14% individuals of Hispanic or Latino ethnicity.

Table 7. Race and Ethnicity

Race	All Individuals % (N=19,761)
White	78.0 (15,421)
African American	15.9 (3,146)
Asian	3.3 (649)
Hawaiian/ Pacific Islander	0.2 (32)
Alaska Native	0.0 (1)*
American Indian	0.5 (96)
Multi-Racial	0.3 (62)
No Race reported	1.2 (238)
Missing Data	0.6 (116)
Ethnicity	
Hispanic/Latino	13.7 (2,712)
Not Hispanic/Latino	86.2 (17,039)
Missing Data	0.0 (10)*

*0.0% represents anything less than 0.5%.

DESCRIPTION OF INDIVIDUALS RECEIVING FULL SCREENING

There are 3,484 records for individuals completing full screening using the AUDIT only (excluding records with AUDIT scores of zero). Table 8 provides the modality assigned by SBIRT staff and score ranges within each modality. The range of AUDIT scores for individuals assigned to each modality indicates potential discrepancies between AUDIT scores and modality selected; for example, individuals in the Screening modality should have AUDIT scores ranging from zero to seven. Refer to Table 2 on page 3 for recommended modality by score.

Table 8. Modality and Scores For Individuals Completing the AUDIT

Screening Instrument	Recommended Service	Number of Records N=3,484	Scores at Screening	
			Range	Median
Completed AUDIT Only	Screening	2,859	1 – 36	4
	Brief Intervention	486	7 – 33	10
	Brief Treatment	60	10 – 37	17
	Referral to Treatment	79	6 – 39	25

Three hundred seventy-nine individuals completed the DAST-10 only (excluding records with scores of zero). Table 9 provides the score ranges for individuals within each modality. Discrepancies with modality selected and DAST-10 scores exist; the 95 records with DAST-10 scores of one or greater should not be assigned to the screening modality based on recommended modality by score (Table 2 on page 3).

Table 9. Modality and Scores For Individuals Completing the DAST-10

Screening Instrument	Recommended Service	Number of Records N=379	Scores at Screening	
			Range	Median
Completed DAST-10 Only	Screening	95	1 – 10	2
	Brief Intervention	207	1 – 10	2
	Brief Treatment	53	1 – 7	4
	Referral to Treatment	24	6 –10	7

There are 527 records for individuals completing both the AUDIT and DAST-10 that have scores greater than zero for at least one screening instrument. Nineteen records with AUDIT scores of one or greater contain DAST-10 scores of zero. It is unknown if the DAST-10 actually was administered since individuals recommended for full screening utilizing the DAST-10 should have a pre-populated response for one question on the DAST-10, yielding a score of at least one. Additionally, there are eleven records with DAST-10 scores of one or greater that contain AUDIT scores of zero, again prescreening response for one question should pre-populate on the AUDIT. Table 10 provides the number of records in each modality with AUDIT and DAST-10 score ranges. The recommended service for an individual completing both screening instruments should reflect the score for the highest level of care. Discrepancies also exist with this group of records, individuals with AUDIT scores greater than seven and DAST-10 scores of one or greater are assigned to the Screening modality. The SBIRT IOWA Project Director has notified staff of correct processes to remedy this situation.

Table 10. Modality and Scores For Individuals Completing the AUDIT and DAST-10

Screening Instrument	Recommended Service	Number of Records N=527	Scores at Screening	
			Range	Median
Completed Both AUDIT and DAST-10	Screening	132	AUDIT 0 – 40 DAST-10 0 – 10	5 2
	Brief Intervention	229	AUDIT 0 – 40 DAST-10 0 – 8	6 2
	Brief Treatment	83	AUDIT 0 – 40 DAST-10 0 – 9	9 4
	Referral to Treatment	83	AUDIT 1 – 40 DAST-10 0 – 10	16 6

There are 1,304 records for individuals receiving full screening whose recommended modality was recorded as Brief Intervention, Brief Treatment, or Referral to Treatment in Year One. Section B of the GPRA is administered to these individuals and contains questions regarding alcohol and drug use in the previous 30 days. It is important to note that the Year One dataset contained 362 records with AUDIT scores of 8 or higher (range 8 – 40) and/or DAST-10 scores of one or higher (range 1 – 10) that were assigned the Screening modality. Therefore, although these individuals had scores that should recommend them for further services, since individuals in the Screening modality do not complete Section B of the GPRA, data on these individuals are not included in this section.

Tables 11 and 12 on the following pages provide information on alcohol and drug use for SBIRT IOWA individuals assigned to the Brief Intervention, Brief Treatment, and Referral to Treatment modalities. Of the 1,304 records, 922 (70.7%) were recommended for Brief Intervention, 196 (15%) were recommended for Brief Treatment, and 186 (14.3%) were offered a Referral to Treatment; 821 (63%) were male and 483 (37%) were female. The following data were self-reported by individuals.

Alcohol and Drug Use

Individuals are asked to report all substances used in the past 30 days. As shown in Table 11, alcohol was the most common substance at screening with 821 individuals (63%) reporting use in the past 30 days. Three hundred seventy-nine individuals (29.1%) reported the use of illegal drugs in the past 30 days, with one quarter of the individuals (25.1%) reporting marijuana use It is important to note that approximately 8% of responses for any given question in Table 11 are missing because individuals declined to answer or responded they did not know, or data are missing.

Table 11. Substance Use

Substance Use in Past 30 Days	All Individuals % (N=1,304)	Males % (N=821)	Females % (N=483)
Alcohol	63.0 (821)	68.1 (559)	54.2 (262)
Methamphetamine	2.1 (27)	1.7 (14)	2.7 (13)
Marijuana/Hashish	25.1 (327)	23.9 (196)	27.1 (131)
Cocaine/Crack	1.8 (23)	1.1 (9)	2.9 (14)
Heroin	0.4 (5)	0.4 (3)	0.4 (2)
Morphine	0.2 (2)	0.1 (1)	0.2 (1)
Diluadid	0.2 (3)	0.1 (1)	0.4 (2)
Demerol	0.0 (0)	0.0 (0)	0.0 (0)
Percocet	0.1 (1)	0.0 (0)	0.2 (1)
Darvon	0.0 (0)	0.0 (0)	0.0 (0)
Codeine	0.1 (1)	0.1 (1)	0.0 (0)
Tylenol 2,3,4	0.2 (2)	0.2 (2)	0.0 (0)
Oxycontin/Oxycodone	0.8 (11)	0.9 (7)	0.8 (4)
Non-Prescription Methadone	0.2 (3)	0.1 (1)	0.4 (2)
Hallucinogens/Psychedelics	0.1 (1)	0.1 (1)	0.0 (0)
Benzodiazepines	0.2 (2)	0.1 (1)	0.2 (1)
Barbiturates	0.0 (0)	0.0 (0)	0.0 (0)
Non-Prescription GHB	0.0 (0)	0.0 (0)	0.0 (0)
Ketamine	0.1 (1)	0.0 (0)	0.2 (1)
Other Tranquilizers	0.1 (1)	0.1 (1)	0.0 (0)
Inhalants	0.0 (0)	0.0 (0)	0.0 (0)
Other Illegal Drugs	1.2 (16)	1.5 (12)	0.8 (4)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer, responded they did not know the answer, or for whom there are missing data varied for each question (approximately 8% of the individuals).
Column totals are not equal to the number of individuals since people report all substances used in the past 30 days.

As shown in Table 12, of the 987 individuals who reported alcohol and/or drug use in the past 30 days, over half reported binge drinking and 151 individuals (15.3%) reported use of alcohol and drugs on the same day. Of the 379 individuals who reported illegal drug use, approximately 3% indicated they injected drugs in the past 30 days.

Table 12. Binge Drinking, Same Day Alcohol and Drug Use, and Injection Drug Use in Past 30 Days

Alcohol and Drugs	All Individuals % (N=987)	Males % (N=651)	Females % (N=336)
Binge Drinking (Five or More Drinks in One Sitting)	58.1 (573)	64.5 (420)	45.5 (153)
Used Alcohol and Drugs on the Same Day	15.3 (151)	14.7 (96)	16.4 (55)
Injection Drug Use	**All Individuals % (N=379)**	**Males % (N=222)**	**Females % (N=157)**
Injected Drugs in Past 30 Days	2.9 (11)	1.4 (3)	5.1 (8)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer, responded they did not know the answer, or for whom there are missing data varied for each question (approximately 8% of the individuals).
Column totals are not equal to the number of individuals.

SBIRT staff administer the GPRA through Section G with individuals designated in the Brief Treatment and Referral to Treatment modalities. There are 382 records for individuals in these categories. It is important to note that although there are over 200 records designated as Screening and Brief Intervention with AUDIT and/or DAST-10 scores that would qualify individuals for Brief Treatment or Referral to Treatment, GPRA Sections C through G were not completed since they were assigned to the Screening or Brief Intervention modality.

Tables 13 through 28 on the following pages provide information from the 382 records in the Brief Treatment and Referral to Treatment modalities for select GPRA questions, these data were self-reported. The following are common characteristics of individuals in SBIRT IOWA recommended for higher levels of substance abuse treatment services:

- Nearly 50% reported owning or renting their own apartment, room or house.
- Nearly 45% experienced stress due to their use of alcohol or other drugs in the past 30 days.
- Just over 50% of the individuals reported having children.
- Approximately 15% did not complete high school, 44% received a high school diploma or the equivalent, and approximately 25% completed some post-secondary education or training.
- Nearly one-third were employed either full or part-time; over 25% were seeking employment.
- Nearly 50% of the individuals reported experiencing serious depression in the past 30 days and over half indicated serious anxiety or tension in the last month. Slightly over one-third reported they were taking medications for mental health issues.
- Many (43.2%) reported experiencing violence or trauma within their lifetime.
- Nearly 50% indicated they have interaction with family and/or friends who are supportive of their recovery.

Family and Living Conditions

Table 13. Housing

Housing Situation	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Shelter	7.6 (29)	10.7 (24)	3.2 (5)
Street/Outdoors	2.4 (9)	1.3 (3)	3.8 (6)
Institution (Hospital, Jail/Prison, Nursing Home)	3.9 (15)	5.3 (12)	1.9 (3)
Own/Rent Apartment, Room, House	49.7 (190)	48.0 (108)	52.2 (82)
Someone Else's Apartment, Room, House	24.9 (95)	26.2 (59)	22.9 (36)
Halfway House	0.0 (0)	0.0 (0)	0.0 (0)
Residential Treatment	0.8 (3)	0.9 (2)	0.6 (1)
Dormitory/College Residence	0.5 (2)	0.9 (2)	0.0 (0)
Housed: Other	1.3 (5)	0.9 (2)	1.9 (3)
Declined to Answer Question	5.2 (20)	2.2 (5)	9.6 (15)
Doesn't Know	0.3 (1)	0.4 (1)	0.0 (0)
Missing Data	3.4 (13)	3.1 (7)	3.8 (6)

Table 14. Substance Use Causing Stress, Reduction in Activities, and Emotional Problems

Stress, Activities, Emotional Problems Due to Alcohol and Drug Use	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Experienced Stress Due to Use of Alcohol or Other Drugs in Past 30 Days	44.8 (171)	47.6 (107)	40.8 (64)
Use of Alcohol or Other Drugs Caused Reduction or Giving Up Important Activities in Past 30 Days	33.2 (127)	35.6 (80)	29.9 (47)
Use of Alcohol or Other Drugs Caused Emotional Problems in Past 30 Days	39.0 (149)	38.2 (86)	40.1 (63)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied. Column totals are not equal to the number of individuals.

Table 15. Children

Children	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Have Children	50.8 (194)	46.7 (105)	56.7 (89)
Children Living with Someone Else Due to Child Protection Court Order	5.2 (20)	2.7 (6)	8.9 (14)
Lost Parental Rights For Any Children	7.1 (27)	4.9 (11)	10.2 (16)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied. Column totals are not equal to the number of individuals.

Table 16. Pregnancy

Pregnant	Females % (N=157)
Currently Pregnant	3.2 (5)*

*Fourteen females declined to answer, data is missing for six females, five responded “don’t know”.

Education, Employment, and Income

Table 17. Level of Education

Education Level		All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Highest Level Of Education	Did not Graduate High School	15.2 (58)	17.3 (39)	12.1 (19)
	High School Diploma/Equivalent	44.0 (168)	46.2 (104)	40.8 (64)
	Some College/University or Associates Degree	17.3 (66)	17.3 (39)	17.2 (27)
	Bachelor’s Degree or Higher	3.9 (15)	3.1 (7)	5.1 (8)
	Voc/Tech Diploma	4.2 (16)	3.1 (7)	5.7 (9)
	Declined to Answer Question	7.1 (27)	4.4 (10)	10.8 (17)
	Doesn’t Know	2.9 (11)	3.1 (7)	2.5 (4)
	Missing Data	5.5 (21)	5.3 (12)	5.7 (9)

Table 18. Employment

Employment	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Employed Full-Time (≥35 hrs/wk)	18.8 (72)	19.1 (43)	18.5 (29)
Employed Part-Time (<35 hrs/wk)	12.6 (48)	11.6 (26)	14.0 (22)
Unemployed, Looking for Work	26.7 (102)	26.2 (59)	27.4 (43)
Unemployed, Not Looking for Work	13.9 (53)	13.8 (31)	14.0 (22)
Unemployed, Disabled	11.8 (45)	15.6 (35)	6.4 (10)
Unemployed, Volunteer Work	0.0 (0)	0.0 (0)	0.0 (0)
Unemployed, Retired	0.8 (3)	1.3 (3)	0.0 (0)
Other	3.4 (13)	3.1 (7)	3.8 (6)
Declined to Answer Question	5.8 (22)	2.7 (6)	10.2 (16)
Doesn't Know	1.3 (5)	1.3 (3)	1.3 (2)
Missing Data	5.0 (19)	5.3 (12)	4.5 (7)

Table 19. Income in Past 30 Days

Total Income Received In Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
None	23.3 (89)	27.1 (61)	17.8 (28)
$500 or Less	21.7 (83)	20.0 (45)	24.2 (38)
$501 to $1000	17.8 (68)	19.1 (43)	15.9 (25)
$1001 to $2000	9.9 (38)	8.0 (18)	12.7 (20)
Over $2000	4.7 (18)	5.8 (13)	3.2 (5)
Declined to Disclose Income, Individual Doesn't Know Income, or Missing Data	22.5 (86)	20.0 (45)	26.1 (41)

Table 20. Sources of Income

Sources of Income Received in the Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Wages	29.1 (111)	28.4 (64)	29.9 (47)
Public Assistance	16.2 (62)	12.9 (29)	21.0 (33)
Retirement	0.0 (0)	0.0 (0)	0.0 (0)
Disability	8.6 (33)	11.1 (25)	5.1 (8)
Family/Friends	3.9 (15)	2.2 (5)	6.4 (10)
Non-Legal Income	0.3 (1)	0.4 (1)	0.0 (0)
Other	10.2 (39)	10.7 (24)	9.6 (15)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for each income category.
Column totals are not equal to the number of individuals since they report income from all sources.

Mental and Physical Health Problems and Treatment and Recovery

Table 21. Overall Health

Self Rating of Overall Health	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Excellent	2.9 (11)	3.1 (7)	2.5 (4)
Very Good	8.6 (33)	10.2 (23)	6.4 (10)
Good	23.0 (88)	23.6 (53)	22.3 (35)
Fair	36.6 (140)	36.9 (83)	36.3 (57)
Poor	17.3 (66)	18.2 (41)	15.9 (25)
Declined to Answer Question	5.8 (22)	2.7 (6)	10.2 (16)
Doesn't Know	0.5 (2)	0.9 (2)	0.0 (0)
Missing Data	5.2 (20)	4.4 (10)	6.4 (10)

Table 22. Inpatient Treatment

Receiving Inpatient Treatment In Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Physical Complaint	3.4 (13)	4.4 (10)	1.9 (3)
Mental or Emotional Difficulties	2.6 (10)	2.2 (5)	3.2 (5)
Alcohol or Substance Abuse	7.6 (29)	8.9 (20)	5.7 (9)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for the three questions.
Column totals are not equal to the number of individuals.

Table 23. Outpatient Treatment

Receiving Outpatient Treatment In Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Physical Complaint	18.3 (70)	19.6 (44)	16.6 (26)
Mental or Emotional Difficulties	11.3 (43)	9.8 (22)	13.4 (21)
Alcohol or Substance Abuse	7.6 (29)	6.7 (15)	8.9 (14)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for the three questions.
Column totals are not equal to the number of individuals.

Table 24. Emergency Room Visits

Receiving Emergency Room Treatment In Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Physical Complaint	12.8 (49)	13.8 (31)	11.5 (18)
Mental or Emotional Difficulties	3.7 (14)	4.4 (10)	2.5 (4)
Alcohol or Substance Abuse	4.7 (18)	4.9 (11)	4.5 (7)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for the three questions.
Column totals are not equal to the number of individuals.

Table 25. Mental Health

Mental Health Issues Experienced In Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Serious Depression	45.8 (175)	43.1 (97)	49.7 (78)
Anxiety or Tension	51.0 (195)	47.1 (106)	56.7 (89)
Hallucinations	5.5 (21)	5.3 (12)	5.7 (9)
Trouble Understanding, Concentrating, or Remembering	32.7 (125)	31.6 (71)	34.4 (54)
Trouble Controlling Violent Behavior	7.9 (30)	8.0 (18)	7.6 (12)
Attempted Suicide	1.6 (6)	1.3 (3)	1.9 (3)
Prescribed Medication for Psychological/Emotional Problems	34.3 (131)	18.2 (41)	28.0 (44)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for the seven questions.
Column totals are not equal to the number of individuals.

Table 26. Violence and Trauma

Experienced Violence or Trauma in Lifetime	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Yes	43.2 (165)	38.2 (86)	50.3 (79)
No	40.8 (156)	48.4 (109)	29.9 (47)
Declined to Answer Question	8.9 (34)	6.2 (14)	12.7 (20)
Doesn't Know	0.5 (2)	0.9 (2)	0.0 (0)
Missing Data	6.5 (25)	6.2 (14)	7.0 (11)

Table 27. Physical Injury

Physically Hurt in Past 30 Days	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Yes	6.5 (25)	8.0 (18)	4.5 (7)
No	79.1 (302)	80.9 (182)	76.4 (120)
Declined to Answer Question	7.9 (30)	4.4 (10)	12.7 (20)
Doesn't Know	1.0 (4)	1.8 (4)	0.0 (0)
Missing Data	5.5 (21)	4.9 (11)	6.4 (10)

Social Connectedness

Table 28. Social Connectedness

Social Connectedness	All Individuals % (N=382)	Males % (N=225)	Females % (N=157)
Attended Any Type of Self-Help Recovery Groups including Religious/Faith-Based, Non-Religious, or any Other in Past 30 Days	24.3 (93)	24.0 (54)	24.8 (39)
Interaction With Family/Friends Who Support Recovery	47.6 (182)	47.1 (106)	48.4 (76)
Have Someone to Turn to When Having Trouble	75.9 (290)	76.0 (171)	75.8 (119)

Note: Data in the table above reflect individuals who answered the questions; the numbers of individuals who declined to answer a question, responded they did not know the answer, or for whom there are missing data varied for the questions.
Column totals are not equal to the number of individuals.

ENCOUNTERS FOLLOWING PRESCREEN AND SCREENING

Encounter data entered in the Iowa Service Management Reporting Tool system (I-SMART) by SBIRT IOWA staff provide the number of services provided to individuals by SBIRT staff following prescreening and full screening. Of the 19,761 individuals receiving prescreening, encounter data exists for 1,671 (8.5%) individuals who had one or more encounter indicating additional services beyond prescreening and screening were provided by SBIRT IOWA staff; 18,090 individuals (91.5%) had no subsequent encounters.

Encounters by the SBIRT modality recorded at prescreening and screening are provided in Table 29 on the following page. The number of encounters with this group of individuals range from one to 13, with a median of one encounter.

Table 29. Individuals with Post-Prescreening or Screening Encounters

Number of Encounters	All Individuals % (N=1,671)	Screening N=626	Brief Intervention N=731	Brief Treatment N=160	Referral to Treatment N=154
One	92.6 (1547)	98.6 (617)	96.3 (704)	70.0 (112)	74.0 (114)
Two	3.4 (57)	10.0 (6)	1.8 (13)	11.9 (19)	12.3 (19)
Three	0.9 (15)	0.0 (0)	0.5 (4)	3.8 (6)	3.2 (5)
Four	0.9 (15)	0.0 (0)	0.1 (1)	6.3 (10)	2.6 (4)
Five	0.5 (9)	0.0 (0)	0.4 (3)	2.5 (4)	1.3 (2)
Six	0.5 (8)	0.2 (1)	0.5 (4)	1.3 (2)	0.6 (1)
Seven	0.2 (4)	0.0 (0)	0.0 (0)	1.9 (3)	0.6 (1)
Eight	0.2 (3)	0.0 (0)	0.0 (0)	1.3 (2)	0.6 (1)
Nine	0.2 (3)	0.3 (2)	0.0 (0)	0.0 (0)	0.6 (1)
Ten	0.2 (3)	0.0 (0)	0.1 (1)	0.0 (0)	1.3 (2)
Eleven	0.2 (3)	0.0 (0)	0.0 (0)	1.3 (2)	0.6 (1)
Twelve	0.1 (1)	0.0 (0)	0.0 (0)	0.0 (0)	0.6 (1)
Thirteen	0.2 (3)	0.0 (0)	0.1 (1)	0.0 (0)	1.3 (2)

Table 30 provides the number and percent of individuals by SBIRT modality for the 18,090 without encounter data. While one would not anticipate an individual in the Screening modality to necessarily receive additional services (although as data presented in Table 29 above indicate some individuals did), information in Table 30 suggests that 259 individuals recommended for additional services chose not to receive any service from SBIRT providers. It is important to note that analyses conducted with treatment admission data obtained from the Iowa Central Data Repository (CDR) reveal six of the 32 individuals (18.8%) recommended for Referral to Treatment in Table 30 were admitted to treatment following SBIRT services: three were referred by a health care provider, two were self-referrals and one was referred by an alcohol/drug abuse provider.

Table 30. Individuals with No Post-Prescreening or Screening Encounters

Recommended SBIRT Modality	All Individuals % (N=18,090)
Screening	98.6 (17,831)
Brief Intervention	1.1 (191)
Brief Treatment	0.2 (36)
Referral to Treatment	0.2 (32)

OUTCOMES

A random 10% sample of individuals assigned to the Brief Intervention, Brief Treatment, and Referral to Treatment modalities are selected to complete a follow-up interview which occurs approximately six months following screening. As previously noted, discrepancies were found with modality selection and recommendations based on AUDIT and DAST-10 score(s). There were 362 individuals assigned to the Screening modality whose AUDIT and/or DAST-10 scores indicated they should be recommended for Brief Intervention, Brief Treatment, or Referral to Treatment. It is important to note that some individuals with AUDIT and/or DAST-10 scores indicating risky, harmful, or dependent substance use are not eligible for the follow-up interview since records assigned to the Screening modality are not included in the random selection process.

At the end of Year One, follow-up interviews had been completed with 33 individuals. Only one individual selected for a follow-up interview had reached the last date of eligibility at the end of Year One and was not interviewed, resulting in a follow-up rate of 97.1% at the end of Year One. Of those who were interviewed:

- Seventeen were female and 16 were male.
- Twenty-two were white, nine were African American, and race was not reported for one.
- None of the individuals reported Hispanic or Latino ethnicity.

Twenty-one individuals who completed the follow-up interview were administered the AUDIT during their initial SBIRT encounter and 23 were screened using the DAST-10. Table 31 provides additional information regarding screening instrument, modality, and scores for the 33 individuals who completed the follow-up interview.

Table 31. Prescreening and Screening Information on Individuals Completing Follow-Up Interview

Instrument Used at Screening for Individuals Completing Follow-Up Interviews	Number of Individuals	Recommended Service	Number of Individuals Within Each Modality	Scores at Screening	
				Range	Median
Completed AUDIT Only	10	Brief Intervention	10	8 – 20	13
		Brief Treatment	0	--	--
		Referral to Treatment	0	--	--
Completed DAST-10 Only	12	Brief Intervention	11	1 – 6	1
		Brief Treatment	1	4	--
		Referral to Treatment	0	--	--
Completed Both AUDIT and DAST-10	11	Brief Intervention	4	AUDIT 4 – 9 DAST-10 1 – 2	5 2
		Brief Treatment	3	AUDIT 0 – 16 DAST-10 3 – 5	3 4
		Referral to Treatment	4	AUDIT 1 – 29 DAST-10 2 – 7	25 5

Changes in Substance Abuse Patterns from Screening to Follow-Up

Table 32 provides alcohol and illegal drug use in the past 30 days at screening and follow-up for individuals completing the follow-up interview; data are self-reported. At screening, nearly half of the individuals (48.5%) reported alcohol use in the 30 days prior to screening. The range of days for alcohol use for these 16 individuals was one to 30 with a median of 5 days (mean = 9 days). For the nine individuals indicating binge drinking at screening, the median number of days they reported drinking five or more drinks in the previous 30 days was six days (mean = 9 days) and ranged from one to 30 days. The number of days of drug use in the 30 days prior to screening for the 18 individuals reporting illegal drug use ranged from one to 30 days (median = 8 days, mean = 11 days).

At follow-up, 11 individuals (33.3%) reported use of an illegal substance in the 30 days prior to their interview, all reported marijuana. Days used in the 30 days preceding the follow-up interview ranged from one to 30 with a median of 8 days (mean = 10 days).

Table 32. Alcohol and Illegal Drug Use at Screening and Follow-Up

Past 30 Day Alcohol and Illegal Drug Use at Screening and Follow-Up N=33		
	Screening % (N=33)	Follow-Up % (N=33)
Alcohol	48.5 (16)	45.5 (15)
Binge Drinking (Five or More Drinks in One Sitting)	27.3 (9)	21.2 (7)
No Use of Illegal Drugs	45.5 (15)	66.7 (22)
Marijuana/Hashish	51.5 (17)	33.3 (11)
Morphine	3.0 (1)	0.0 (0)
Oxycontin/Oxycodone	3.0 (1)	0.0 (0)
Benzodiazepines	3.0 (1)	0.0 (0)
Injected Drugs in Past 30 Days	0.0 (0)	0.0 (0)
Used Alcohol and Drugs on the Same Day	12.1 (4)	12.1 (4)

Note: Column totals are not equal to the number of individuals since people report all substances used in the past 30 days.

Analyses of treatment admission data obtained from the CDR indicate two individuals who completed the follow-up interview were admitted to substance abuse treatment following SBIRT screening: one in the Brief Intervention modality and one in the Referral to Treatment modality, one was a self-referral and one was referred to treatment by another individual.

Individuals in the Brief Intervention modality (25 of the 33 individuals who completed a follow-up interview) do not complete the full GPRA at screening. As more people in the Brief Treatment and Referral to Treatment modalities complete follow-up interviews, data on additional outcome variables may be provided in future reports.

ADDITIONAL ANALYSES

Factors Associated with Outcomes

Encounters and Sex:

Data on whether or not an individual had subsequent encounters by SBIRT following prescreening and screening was analyzed as an outcome and also as an indicator for potential dropout. Table 33 shows the percent of males and females who had subsequent encounters broken down by their recommended SBIRT modality. Analyses indicate there were no significant differences between males and females in the likelihood of having a successful (additional) encounter following prescreening and screening. Similarly, there were no significant differences between the number of encounters for any modality.

Table 33. Receiving One or More Encounter By Sex and Modality

Sex	Screening N=18,457	Brief Intervention N=922	Brief Treatment N=196	Referral to Treatment N=186
Male	3.4%	78.2%	81.7%	81.9%
Female	3.4%	81.3%	81.6%	84.3%

Encounters and Race/Ethnicity:

While many of the race/ethnic categories have too few individuals to make accurate statistical inferences, there are some trends noticeable in the data thus far as shown in Table 34 on the following page. African American individuals referred for Brief Interventions or assigned to the Screening modality were more likely than other individuals to have a subsequent encounter (χ^2-tests, p's < 0.001). On the other hand, Latino individuals were less likely to have an encounter for either Screening or recommendation for Brief Intervention (χ^2-tests, p's < 0.001).

American Indian individuals in the Screening modality were more likely to have a subsequent encounter than other groups (χ^2-test, p < 0.001). However, there are early signs of a possible problem among the American Indian group who received a recommendation for a higher level of care. Although there were very few cases (n = 3), none of the American Indians who were recommended for Brief Treatment had an encounter and this was statistically different from the percent for all others (0% versus 81.9%; Fisher's exact test, p < 0.001). Referral to Treatment had a similar result (0% versus 82.8%; Fisher's exact test, p < 0.03).

The only other significant effect appeared among Asian individuals. The probability of an encounter following a Screen was less than that in other groups (χ^2-test, p < 0.004).

Table 34. Receiving One or More Encounter By Race and Ethnicity

Race/Ethnic Group	Screening N=626	Brief Intervention N=731	Brief Treatment N=160	Referral to Treatment N=154
White	3.3%	77.6%	81.0%	82.8%
African American	4.6%	87.4%	85.7%	90.9%
Latino	1.4%	33.8%	--	--
American Indian	4.8%	--	--	--
Asian	1.4%	--	--	--
Pacific Islander	0.0%	--	--	--
Alaska Native	--	--	--	--

Note: Cells with fewer than 25 observations were excluded.

Encounters and Age:

Whether or not an individual received an encounter was strongly predicted by the individual's age (Wald χ^2-test, $p < 0.0001$) as shown in Table 35. A large part of this effect of age was determined by the fact that more intensive SBIRT modalities were often seen in the younger age groups. However, analyses that are more sophisticated suggested an age effect may exist beyond the modality factor although the effects and their direction are unclear. Since there are few cases of higher intensity modalities and individuals in the older age groups, these effects will be closely monitored as more data become available.

Table 35. Receiving One or More Encounter By Age

Age Group	Percent with Encounter
18 – 24 Years	10.3%
25 – 34 Years	11.1%
35 - 44 Years	9.1%
45 - 54 Years	8.7%
55 - 64 Years	6.1%
65+ Years	1.9%

Encounters and Socio-Economic Indicators:

No analyses were performed with socio-economic indicators since these variables are not being recorded by staff except for those receiving a modality of Brief Treatment or Referral to Treatment. For example, income from wages, income from public assistance, and education are missing for over 93% of all Year One records. Even among those cases where data are recorded, more than 50% of the cases have the income variables recorded as zero. Even considering zeros as no income from that source and constructing a total income from any source produces missing values (or zero) in over 45% of the relevant records.

Follow-Up Data and Sex, Race/Ethnicity, and Socio-Economic Indicators:

In Year One, there were only 33 follow-up interviews conducted. As previously noted, this included 22 whites, nine African-Americans, and one American Indian individual. Thus, sample sizes were too small for additional analyses. In future years, analyses will be conducted for change in substance use patterns for subgroups including age, sex, race, ethnicity, recommended modality, and (if possible) socio-economic analyses of drop-outs (i.e., no GPRA follow-up) and, possibly, other outcome indicators from the follow-up GPRA interviews including effects in individual's physical and mental health and other GPRA outcomes.

Analysis of Iowa Treatment Admission Data

Treatment admission data obtained from the Iowa Central Data Repository (CDR) was examined to determine if individuals receiving any SBIRT services in Year One were admitted to substance abuse treatment in Iowa following their SBIRT screening date. One hundred fifty-four admission records were located in the CDR. Treatment admissions for these individuals occurred at 23 treatment agencies in Iowa. The median time from SBIRT screening to treatment admission was 43 days (range was zero to 223 days).

Table 36 provides information regarding reported sources of referral for treatment admission by SBIRT modality. The percentage of individuals reporting that they were referred by a health care provider seems to increase from BI to BT and to RT (exact Cochran-Mantel-Haenszel correlation, $p < 0.03$).

Table 36. Referral Sources for Individuals with Treatment Admissions

Source of Referral From Admission Record	N	Screening % (N=112)	BI % (N=13)	BT % (N=9)	RT % (N=20)
Self Referred	33	22.3 (25)	15.4 (2)	22.2 (2)	20.0 (4)
Health Care Provider	25	10.7 (12)	7.7 (1)	33.3 (3)	45.0 (9)
Alcohol/Drug Abuse Provider	13	8.0 (9)	7.7 (1)	11.1 (1)	10.0 (2)
Other Individual	4	1.8 (2)	7.7 (1)	0.0 (0)	5.0 (1)
OWI	12	8.9 (10)	15.4 (2)	0.0 (0)	0.0 (0)
Other Criminal Justice/Court	19	15.2 (17)	7.7 (1)	11.1 (1)	0.0 (0)
Civil Commitment	2	1.8 (2)	0.0 (0)	0.0 (0)	0.0 (0)
Drug Court	2	1.8 (2)	0.0 (0)	0.0 (0)	0.0 (0)
Other Community	5	2.7 (3)	0.0 (0)	0.0 (0)	10.0 (2)
DHS Child Abuse	1	0.9(1)	0.0 (0)	11.1 (1)	0.0 (0)
DHS Child Welfare	3	2.7(3)	0.0 (0)	0.0 (0)	0.0 (0)
DHS Drug Endangered Child	1	0.0 (0)	0.0 (0)	11.1 (1)	0.0 (0)
DHS Other	7	2.7 (3)	15.4 (2)	0.0 (0)	5.0 (1)
State Probation	25	18.8 (21)	23.1 (3)	11.1 (1)	5.0 (1)
Federal Probation	2	1.8 (2)	0.0 (0)	0.0 (0)	0.0 (0)

SITE VISITS

An evaluator from the Consortium visited the five sites approximately three months after sites began providing SBIRT services, one site visit was delayed due to weather issues. Qualitative data were collected using two methodologies: by conducting a focus group at each site and completing key staff interviews with staff responsible for supervising the SBIRT project. Some of the information in this section is based, in part, on recordings and notes from focus groups and interviews.

Table 37 provides the location, the service provider, the substance abuse treatment agency working in coordination with the service provider, the date the site began conducting SBIRT services, and the date of the evaluator's site visit.

Table 37. Site Visit Information

County	Service Provider	Substance Abuse Treatment Agency	Date SBIRT Services Began	Date of Site Visit by Evaluator
Scott Co.	Community Health Care, Inc.	Center for Alcohol & Drug Services, Inc.	10/25/12	1/25/13
Statewide	Iowa National Guard	House of Mercy and United Community Services	11/03/12	2/1/13
Woodbury Co.	Siouxland Community Health Center	Jackson Recovery Centers	11/14/12	4/8/13*
Blackhawk Co.	Peoples Community Health Clinic	Pathways Behavioral Services	11/15/12	3/8/13
Polk Co.	Primary Health Care, Inc.	MECCA Services	11/27/12	3/29/13

*Site visit originally scheduled for 2/22/13 was postponed due to inclement weather.

Focus Group Summary

The SBIRT IOWA Project Director provided a non-random targeted list of staff members selected for focus group participation to the evaluator; all were directly involved in the SBIRT project. Twenty-seven staff members from the five sites participated in focus groups. At each site, at least one staff member from each organization (service provider and substance abuse treatment agency) involved in SBIRT participated in the focus group with the exception of one site, where a representative from the substance abuse treatment agency was not present. Focus group participants included physician assistants, nurses and nurse practitioners, social workers, behavioral health counselors and consultants, substance abuse treatment counselors, medical assistants, and health educators.

Questions were provided in advance to the focus group participants to allow for the opportunity to prepare. All focus groups were facilitated by the evaluator from the Consortium and each lasted approximately one hour. Discussion took place in an effort to obtain information regarding training provided to staff, the implementation and incorporation of SBIRT services into the workflow, the effect of the SBIRT process on workflow, challenges and barriers, and successes. Participants were given a stamped envelope addressed to the evaluator to send

additional thoughts or comments to the Consortium following the focus group. Additional feedback was received from three participants and is included in the summary. Participants were cooperative and provided constructive information and feedback regarding the SBIRT IOWA project. At four of the five sites, SBIRT services are provided to patients seeking medical treatment; the manner in which SBIRT services at the other site are provided to Iowa solders is unique due to the nature of the Iowa National Guard. Due to the differences, information collected from focus group participants for the four sites providing SBIRT services at FQHCs are combined and the National Guard information is separate for some topics.
The following summarizes the information provided to the evaluator during the focus group discussions.

Training:

Staff participating in the focus group discussions indicated the education, training and events offered in Year One by IDPH as being valuable in an effort to successfully implement SBIRT services. Staff discussed many opportunities provided to assist in the preparation to implement SBIRT services including: webinars and trainings offered by IDPH, informational links on the IDPH SBIRT webpage including the research links, performing additional searches online, meetings with IDPH staff, as well as internal orientations and trainings provided for staff within each service provider organization. Due to the unique nature in which SBIRT was implemented at the Iowa National Guard site, additional training was provided to the co-located substance abuse treatment counselors to facilitate their understanding of the military culture and ranking system. The treatment counselors working with the National Guard also actively participated in resiliency training with the troops.

In general, there was positive feedback regarding trainings during focus group sessions. Many participants indicated no further training was necessary and staff from several sites discussed the continuing need to learn, adjust, and adapt as they go along. However, discussion took place at one site regarding the necessity of future trainings to stay up to date with the newest processes and information. Participants offered feedback and suggestions for trainings including the need for trainings and webinars to move faster (one participant felt some are “snail paced”), trainings to be more condensed, and trainings that are not so lengthy, providing the example that a three hour webinar is difficult for staff to sit through with many other work duties and obligations at busy sites operating at fast paces. Several participants suggested training on how to deal with people who are resistant would be helpful.

Workflow:

Medical Clinics
Participants were asked to discuss SBIRT implementation and describe the process that has been incorporated into the medical clinic. This includes the roles of staff and the process patients go through as they move through the medical clinic setting. Each medical clinic varies slightly, however, there are general similarities expressed by focus group participants. When patients check into the clinic for an appointment with a primary physician, they are taken to the exam room and the two SBIRT prescreen questions are incorporated into the routine with other general health questions asked of patients. Medical staff ask the two prescreening questions; staff administering the prescreening varies by site and include nurses, medical assistants, and patient clinic representatives. When patients prescreen positive, the medical staff use a variety of methods including telephones, pagers, and radios to alert staff that further screening needs to be completed. Staff administering the full screen AUDIT and/or DAST-10 vary by site and include social workers, behavioral health counselors or consultants, and health educators.

Staff from two sites indicated they currently used paper forms to collect prescreening and screening responses; one site conducted prescreens and screens on paper initially and now utilizes a computer system; and one site did not discuss the method.

Individuals who screen positive are offered Brief Intervention, Brief Treatment, or Referral to Treatment based on AUDIT and DAST-10 scores. Staff from all sites discussed the need to use clinical judgment to offer or provide higher or lower levels of service. Staff providing Brief Intervention vary across sites, most commonly this service is provided by social workers, behavioral health counselors and consultants, and health educators. The substance abuse treatment counselors provide Brief Treatment or assist with Referral to Treatment at all four medical clinic sites.

Participants from all sites discussed the need for flexibility of staff and processes within the medical clinics in an effort to minimize disruption to the clinic workflow and the patient's appointment with the physician. The physician's appointment with the patient is priority, therefore screenings and Brief Interventions are conducted before or after the appointment with the physician at all sites.

Focus group participants indicated that due to the time commitment and paperwork involved with scheduling patients for Brief Treatment and Referral to Treatment, discussion with patients regarding these services usually takes place following the appointment with the physician. Additionally, participants explained Brief Intervention or meeting with patients to discuss treatment cannot always be completed during the patient's appointment due to patient time constraints or staff not being available. When this occurs, staff at the sites indicated they sometimes attempt to call the patient back later, however many patients are not reached or when contacted, patients do not want any further screening or information. Some focus group participants reported they feel not all data is being captured since patients who do not show up for their initial meeting with the substance abuse treatment counselor or do not show up for later appointments (some estimate 50% of patients do not return for further SBIRT services), do not have information entered into the I-SMART system. The SAMHSA Project Officer has recently addressed this concern and staff are now manually tracking patients who fit in this category.

Staff from all sites reported encountering patients who are identified for Brief Treatment or Referral to Treatment and decline those levels of service. When this occurs, staff indicate they provide contact information to patients if they change their mind in the future. Participants at one site discussed a unique situation they feel complicates their numbers and data. Many patients who screen positive are already receiving substance abuse treatment since treatment agencies in their area send clients to the medical clinic for physicals and other medical procedures. In these situations, clients already in treatment are pre-screened, screened, and staff ask the required Government Performance and Results Act questions (GPRA), however patients refuse the level of care suggested since they are already in treatment.

Participants from all sites indicated patients are "slipping through the cracks" and not receiving pre-screening. Additionally, not all sites initially attempted to pre-screen every patient entering the medical clinic. Various reasons discussed during focus groups as to why people are not receiving pre-screening and additional screening when pre-screens are positive include:

- Medical staff not remembering to pre-screen.
- Staff who administer full screening not present in the clinic, in a meeting, or working with another patient when someone pre-screens positive.
- Medical staff not always alerting SBIRT staff of a positive pre-screen.

- Not all physicians in the clinic allowing pre-screens with their patients. However, staff from one site discussed a physician who currently does not allow pre-screening, but will contact SBIRT staff if there is concern about an alcohol or drug issue with a patient.
- Sites with multiple satellite clinics and not enough SBIRT-trained staff to be present at each clinic at all times.

Iowa National Guard

The SBIRT project was individualized for the Iowa National Guard since it is not a health care center. Two substance abuse treatment counselors from two treatment agencies provide all levels of service for SBIRT including pre-screening, screening, Brief Intervention, Brief Treatment, and Referral to Treatment.

The following information provides the different methods through which the soldiers receive SBIRT services.

- SBIRT services are incorporated into the annual periodic health assessments (PHA) that soldiers receive through the National Guard at Camp Dodge or at armories around the state. Soldiers visit stations for a variety of physical, mental, and dental health screenings. The substance abuse treatment counselors attend PHA events and are located in a corner or different room in an effort to protect confidentiality. Focus group participants estimate two counselors can provide SBIRT services to approximately 200 soldiers in one day.
- Soldiers are referred for SBIRT services when they receive a Serious Incident Report (SIR) after an alcohol or drug incident. For example, when a soldier tests positive for drug use during routine drug screening, they are referred for SBIRT services. The SBIRT project coordinator at the Iowa National Guard is notified and the treatment counselors become involved.

Focus group participants indicated the two pre-screening questions are either administered on paper or in person. Counselors stated during the focus group they feel asking questions face to face is more accurate and preferable to reduce discussion among soldiers and possible rehearsal of answers. Soldiers who pre-screen positive complete the AUDIT or DAST-10; when scores reveal the need for Brief Intervention, counselors provide that immediately. If soldiers score for Brief Treatment or Referral to Treatment, counselors begin discussing the process immediately and attempt to initiate the service in the most convenient way for the soldier. The counselors can provide Brief Treatment either in their office, by telephone, or through virtual counseling using Defense Connect Online, a secure online Skype system accessible by all military personnel. For soldiers scoring as needing Referral to Treatment, counselors locate and refer them to treatment providers near their hometown since many of them live all over the state. Participants discussed the need to take mental health issues into consideration due to the high number of soldiers experiencing a range of symptoms.

Follow-Up Interview:

The evaluator obtained information during focus groups regarding the SAMHSA requirement that 10% of individuals assigned to the Brief Intervention, Brief Treatment, and Referral to Treatment modalities are selected for the follow-up interview to be conducted approximately six months after the screening. Participants at all sites indicated they explain the interview to those selected, obtain consent, signed release forms, and the required contact information. Staff participating in this process vary at each site and include social workers, behavioral health counselors or consultants, and substance abuse treatment counselors. To ensure those selected for the follow-up interview can be located when the interview is due, staff discussed the

IDPH requirement that individuals must provide information for at least two collateral contacts. Participants at several sites indicated difficulty in obtaining two collateral contacts from some individuals. They reported when this occurs, since the system requires information for two different contacts, individuals who are unable to provide the required information are not eligible for the follow-up interview. Due to this suggestion and feedback, the SBIRT IOWA Project Director made system changes in May, and only one collateral contact is now required to be entered, although staff are encouraged to obtain as many as possible.

Participants discussed varying methods used to track people selected for the six month follow-up interview, including development of spreadsheets and setting calendar reminders. Sites vary on how frequently they attempt to contact people to stay in touch and remind them of the interview. At two sites, the substance abuse treatment counselor attempts to call everyone selected for a follow-up interview once a month; one site estimated approximately 40% had been reached and the other site estimated 95% had been reached. One site plans to contact people approximately three months following the screening and at the time of the focus group, no one selected for follow-up had reached the 90 day point yet. One site had not yet attempted to remind anyone selected for the follow-up interview and planned to call people one month before the interview is due. One site indicates they kept in good contact with individuals selected for the follow-up interview who have received Brief Treatment or Referral to Treatment; those who received Brief Intervention have not been contacted, however focus group participants expressed they did not anticipate a problem locating them for follow-up interviews.

Participants at one site discussed the mobile and transient population they encounter and the difficulty they may encounter staying in touch with patients. Discussion took place during one focus group suggesting a system to alert staff when an individual selected for the follow-up interview returns to the medical clinic so other staff can remind the patient about the interview and update contact information during the medical appointment.

Challenges and Barriers:

As to be expected during the implementation of a large project involving coordination of many staff members and processes, focus group participants discussed many challenges and barriers they encountered during the initial stages of the SBIRT IOWA project. Staff from several sites indicated they are still working on smoothing the process and problems out.

The following common themes emerged. Some comments made to the evaluator during focus groups have been paraphrased.

<u>Training and Preparing for Implementation</u>

- Allow for flexibility based on the nature and needs of each site. A “one size fits all” approach is restrictive. Staffing assignments, the process of patient flow, and other requirements of the grant should be decided at each site based on the unique aspects of the site as determined by staff managers versus state grant oversight staff.
- Make sure that all training includes the critical tasks needed for proper completion of expected work by staff. If learning is to be done independently by reading, then required areas should be emphasized during in-person training sessions, for example “Be sure to read….”.
- Clearer expectations for I-SMART charting.

Interface

Two sites discuss the urgent need for the interface IDPH promised to provide and the following comments were made during focus groups:

- *"It is hard to train staff who are using electronic medical records where all the forms they use are located, but here is this paper one. That makes us this funny little silo instead of being integrated."*
- The amount of time to perform data entry. *"Sometimes I can be here until 10:30 at night without the interface doing data entry. I sit there like a monkey and enter the data."*
- *"The lack of the interface is our barrier. It will help eliminate repetitive pre-screening since staff will be able to see it has been done. Guidelines were not in place initially, a lot of people were getting pre-screened twice. Although this is not that big of a deal, sometimes people get really irritated easily over small things. I wish we could have done this earlier, identify that they were already pre-screened sooner than we did."*
- *"The interface is the key to everything in terms of the continuity. If we don't get those pre-screens, it doesn't go on. It's a domino effect."*

Obstacles with Participants

- People who do not follow through with services.
- *"For a lot of our patients, transportation is an issue. Just to come back, sometimes it is not that they do not want to do it, it's just that it's a matter of them having to get somewhere or if they have to make arrangements with work or kids or anything else. Our patients are a lot about convenience."*
- Motivating people to return for Brief Treatment or Referral to Treatment, participants expressed many are scheduled and do not show up.

GPRA

Another common topic discussed was the GPRA interview required with people recommended for the higher level of treatment services, including the following comments:

- *"When spending time doing the full GPRA with a patient, I miss seeing other patients I need to see."*
- *"The GPRA contains many questions that don't apply to the medical reason for which the patient is being seen. Since they need to be asked in a standardized way, they are sometimes repetitive of questions patients have already been asked as part of their medical exam. One person said, 'are you an idiot? I just told you!' Some patients get angry and agitated."*

Additional Challenges Discussed

Sites varied on additional challenges they discussed during focus groups. Many expressed challenges concerning staff time, availability, workflow issues, and attitudes.

- Not having enough staff and staff being spread out at different sites and multiple exam rooms. *"Because, for me, I think the best time to do it (SBIRT service) is when they (the patient) are in that place when they are actually thinking about it. If I try to call the next day, that might be enough time for them to say 'no, I don't really have a problem, never mind'. There is a small percentage willing to return. If they don't return, we throw away prescreens and they do not get entered."*
- Patients pre-screening positive are missed due to other job obligations of staff who conduct screens.
- *"We are not able to get to all the patients that need our care, they are missed."*

- Lack of training in terms of expectations. *"The numbers IDPH has do not reflect the correct numbers due to misunderstandings."*
- *"We have a lot of the barriers because we are in a community health center, they have to be in a certain socio-economic group. Also, literacy, a lot of them are illiterate, they don't understand or aren't willing to change. A lot of them are non-compliant, even with medical care. So staff are dealing with a lot of those issues as well."*
- Prioritizing the multiple tasks that need to be done with patients.
- *"Sometimes a barrier for me is the process of getting somebody set up for a brief therapy session. It takes a little longer, and I know how busy the providers are and how busy it (the office) is and has to keep moving. I try to do things faster and I think that's actually a barrier for me."*
- *"There are some limitations in our current process in handing off patients from one staff member to another so we're making sure we are getting the entire program implemented. That can be improved on."*
- *"The purpose of this is to identify not if they have a problem, but how, if any, their alcohol could be affecting their health. So just our change in thinking, I think that is something we need to continue to do, to change our thought process about it. That it is not to find out who has a problem, but this is just another intervention within their overall health checkup."*
- National Guard: *"Our numbers are going to be dependent upon how many PHAs are in a certain timeframe. For us that has been kind of a challenge, kind of a barrier for us in the sense that we can't just keep the flow coming all the time."*

Successes:

Focus group participants discussed many successes as a result of the SBIRT IOWA project. Two common themes stood out, the benefit of integrating a substance abuse program with medical services and the value the project provides to people in Iowa. Some comments made by multiple participants have been summarized and include the following highlights:

<u>Combining Medical Care and Substance Abuse</u>

- *"The biggest success was just getting this thing going. It seemed like an uphill battle for a while."*
- Integrating this project into a primary care setting, *"it has permeated the clinic"*.
- Having nurses and medical providers being on board and having their support in implementation of the project. Medical staff understanding the concept of the program, being enthusiastic, and understanding the benefit to the patient.
- Developing multiple systems of delivery.
- Collaboration.
- The receptiveness on the part of the officers in the National Guard.
- Medical staff understanding the concept of the program, being enthusiastic, and understanding the benefit to the patient.

<u>Benefit to Participants</u>

- Increase in resources and tools available to provide to individuals interested in seeking substance abuse treatment.
- Educating patients on how alcohol affects physical health, we are making positive changes in our patients' lives.

- Educating patients about how alcohol affects physical health, even extending to staff members realizing they may be drinking at an unhealthy level based on the definition of one drink.
- The relationship building this program allows staff to have with individuals.
- Participants who initially decline SBIRT services and later return and express to staff the Brief Intervention made them more aware. Some patients have returned asking for information and/or treatment: "*We made it her choice, not our choice".*
- The small, but meaningful success stories with patients.
- Patients who want to share the information and handouts with others including family members and friends, *"so it is not limited to just our patient population"*.
- *"When we present it as we are not identifying problems, we're assessing risk. And that all of the sudden, that changes your point of view instantaneously. When we give them the example that our screening is like a blood pressure screening. It is just a preventative measure that we're going to do, so that if there is an issue, we can intervene quickly."*
- *"Because this is a place you can be honest. You know, the law is not involved here. This is not about legality, this is about health, this is about wellness, and this is about getting people what they need."*

Overall, focus group participants were positive about SBIRT IOWA, working collaboratively, and helping Iowans. Many expressed they look forward to the future of the project as indicated by the following comment made by one focus group participant*: "I'm anxious to see where we are at a year from now".*

Recommendations Discussed During Focus Groups:

In addition to previous suggestions, the following additional comments made by focus group participants may be taken into consideration by IDPH staff.

- Have the Iowa National Guard offer trainings through IDPH for substance abuse treatment providers in Iowa to provide information regarding the military culture due to the likely increase in members of the military and veterans obtaining treatment services in the future.
- Explore the stigma associated with substance abuse within individual organizations.
- An annual meeting for staff from all sites to get together to discuss successes, challenges, workflow, best practices, etc.
- Provide scanners and shredders to treatment counselors working with the Iowa National Guard to enable them to scan documents to their computers so they could then shred the paper documents at PHA events. The need to streamline this process will save time, eliminate the need to carry all the paperwork back to the office, and reduce interfering with other staff sharing office equipment.
- Provide option to open closed charts in I-SMART for individuals that decide they want help at a later time.
- Get to know the Iowa National Guard SBIRT program better (during the focus group discussion it was unclear who this comment was intended for).
- Consortium staff spend time with leaders from the National Guard to find out what additional data could be provided to protect other areas such as unique populations.

Key Staff Interviews

A list of staff members selected for the key informant interviews was provided to the evaluator by the SBIRT IOWA Project Director. Interviews were conducted with 16 staff members and included supervisors and the substance abuse treatment counselor at one site.

Interview participants were provided the list of questions prior to their scheduled interview to allow the opportunity to prepare in advance. All interviews were conducted one-on-one by the evaluator from the Consortium. Questions were asked regarding internal communication and staff feedback, the effect of SBIRT on workflow, attainment of target numbers, staff support and trainings, successes, challenges, technical assistance needs, and future training suggestions. Participants were cooperative and provided constructive information and feedback regarding the SBIRT project. Responses to each question are synthesized and provided below.

Communication:

Supervisors at all sites indicated they receive staff feedback on a regular basis. Most clinics schedule weekly meetings to discuss SBIRT, a few supervisors meet with staff monthly. Topics discussed during meetings include how the project is going, the numbers of screenings conducted, successes, barriers, lessons learned, and ways to improve. SBIRT discussions are often integrated into larger staff or departmental meetings. Supervisors at several clinics mentioned more frequent meetings in the beginning of the project that have since tapered off as it has become more routine. Supervisors indicated they have informal meetings or discussions with staff when any issues or questions arise. Communication occurs via email, phone calls, or in person.

Workflow:

Most supervisors at health clinics reported some initial skepticism from medical staff, including concern with the additional questions being time consuming for staff. Reluctance came particularly from those doing prescreening, as their workloads are generally very large and they are already asking patients many questions. Some degree of trial and error in figuring out the process as it was implemented was discussed during many interviews. Supervisors from two clinics mentioned some patient resistance due to the extra time spent at the clinic due to the addition of SBIRT services. Flexibility and working around the medical provider's schedule has been very important at all sites. Many of those interviewed discussed the lack of computer interface making the process time consuming.

Target Numbers:

Staff from all sites indicated difficulty reaching target numbers in the early months of the project. Issues came from not having enough providers or clinics involved and not prescreening or conducting the full screen with all patients. Some clinics intentionally limited the number of physicians working on the project in the beginning in order to monitor the process and work out any issues before expanding. Some participants discussed initial problems getting staff buy-in and staff remembering to do the prescreening. Strategies to reach the target numbers include providing incentives to staff and expanding to satellite clinics and/or including more physicians in the SBIRT process.

Staff Support and Trainings:

Although there was skepticism on the part of many staff members initially, respondents indicated nearly all staff are now supportive and enthusiastic about the program. Seeing the

benefits for the patients and communicating the overarching goals of the program helped gain support. Many supervisors were uncertain of exactly what training medical staff had received, but reported staff viewed several webinars on the overview of SBIRT, target population, statistics on substance abuse, and motivational interviewing.

Challenges:

The most common barriers mentioned were the lack of computer interface and the negative effects of incorporating the SBIRT process on the patient workflow, especially in the initial stages of the project. As the interface becomes available, staff highly anticipate the reduction of data entry time and a smoother integration of SBIRT into the workflow and with the electronic health records. Some participants reported staff did not have enough training in the I-SMART system and that it could be slow and cumbersome. Getting people to follow-through and engage with SBIRT was also mentioned as a barrier.

Successes:

Many respondents felt the integration of SBIRT into the clinic workflow and the cultural shift to viewing substance abuse as an important piece of primary, preventative care has been valuable. Many indicated each individual intervention is seen as a success. Supervisors expressed their staff and clinics are increasing patient knowledge and improving their quality of life. Several supervisors mentioned the partnerships between substance abuse treatment agencies and health centers and successful collaboration of staff members as a big success.

Training Suggestions:

Many staff participating in the key informant interviews recognized the importance of on-going training and education for all staff, including support staff and medical staff. One person felt this is absolutely necessary to keep staff committed and provide quality SBIRT services. Several supervisors requested more training on motivational interviewing for staff. One suggested this occur on a semi-annual or annual basis, another requested it be offered to all staff in the clinic so they use a similar language when discussing patients. One suggestion was training on motivating people to return for Brief Treatment or follow through with treatment referral since many who are scheduled for these events do not show up. Several participants also requested more substance abuse and addiction training for healthcare providers and substance abuse counselors, including trainings on how alcohol use and abuse and substance abuse can affect certain chronic medical conditions; they feel both sides need a better understanding of how their work overlaps. One supervisor also suggested that substance abuse counselors and staff might benefit from basic training on clinic situations including bedside manner and how to operate in a clinical setting. Another suggested trainings regarding a better base of medical knowledge for social workers and other SBIRT staff.

RECOMMENDATIONS FOR YEAR TWO

In the course of analyzing data for this report and reviewing information obtained during focus groups and key informant interviews, the following information and suggestions may be advisable.

Annual Prescreening and Screening:

Although the policy manual states individuals are to be screened annually unless a significant event arises, in the process of analyzing data for this report, duplicate records for 32 individuals

were identified in Year One data. These records were inadvertently included in analyses conducted for this report. Although this is a trivial situation now and produces nominal issues for the analyses (less than 0.2% of individuals receiving SBIRT services in Year One), the issue will become more problematic in subsequent reports. The Consortium and IDPH staff will discuss the process to determine which record to include when an individual has multiple records and filters will be put in place to avoid this situation in the future. Of duplicate records, over half of the individuals were recommended for a higher level of service at their second screening, hopefully resulting in individuals receiving needed services. Approximately one third were in the same modality at both occurrences, nearly two thirds moved to a higher level of recommended service from first to second screening, and approximately 10% were assigned to a modality recommending a lower level of service. Table 38 provides modalities at each prescreen/screen for these 32 individuals:

Table 38. Modality for First and Second Prescreen/Screen

Modality Selected for First Prescreen/Screen	Modality Selected for Second Prescreen/Screen	Number of Individuals % N=32
Screening	Screening	31.3 (10)
Screening	Brief Intervention	15.6 (5)
Screening	Brief Treatment	21.9 (7)
Screening	Referral to Treatment	12.5 (4)
Brief Intervention	Brief Treatment	9.4 (3)
Brief Intervention	Referral to Treatment	3.1 (1)
Referral to Treatment	Brief Treatment	3.1 (1)
Referral to Treatment	Brief Intervention	3.1 (1)

Positive and Negative Responses for GPRA Screening Question:

IDPH was notified of the inconsistency answering GPRA question 2a previously mentioned in this report. The Consortium will analyze data during Year Two for this question and provide feedback to IDPH. However, these "accidental" data will allow us to calculate the reliability (test-retest) of the screening in the future.

Screening Scores and Modality:

There are inconsistencies with AUDIT and DAST-10 scores corresponding to modality entered by SBIRT staff. The Consortium has notified IDPH. To remedy the situation, IDPH staff are in the process of putting measures in place so that AUDIT and DAST-10 scores more accurately correlate to the modality assigned to individuals. The Consortium recommends as data problems are identified, they should be corrected. Ideally, corrections should be made as close to the source information as possible (e.g., at the site). Furthermore, corrections must be accompanied with complete documentation including the nature of the error and correction, when it was discovered and by who, and when it was corrected in order to explain why data may change in subsequent reports.