CURRICULAR RESOURCE ON
Screening, Brief Intervention and Referral to Treatment (SBIRT)

Mapping CSWE 2015 EPAS to SBIRT

Developed by NORC at the University of Chicago in collaboration with CSWE.

CSWE
COUNCIL ON SOCIAL WORK EDUCATION

NORC
at the UNIVERSITY of CHICAGO

ADOLESCENT
SBIRT
Screening, Brief Intervention & Referral to Treatment

CURRICULAR RESOURCE ON
Screening, Brief Intervention and Referral to Treatment (SBIRT)

Mapping CSWE 2015 EPAS to SBIRT

This document is provided to enhance practice behaviors and apply knowledge for social work practice when screening and intervening with individuals engaged in substance * *misuse, using each of the nine competencies outlined by the Council on Social Work Education in 2015.*

CONTRIBUTORS

Catherine M. Lemieux
Louisiana State University

Joan M. Carlson
Indiana University

Lisa Berger
University of Wisconsin- Milwaukee

Paul Sacco
University of Maryland

NORC AT THE UNIVERSITY OF CHICAGO

Tracy McPherson
Senior Research Scientist, NORC at the University of Chicago

Hildie Cohen
Research Director, NORC at the University of Chicago

COUNCIL ON SOCIAL WORK EDUCATION

Darla Spence Coffey
President and CEO

Jo Ann Regan
Vice President of Education

Julie Rhoads
Director, Educational Initiatives and Research

Andrea Bediako
Former Associate Director, Education Initiatives and Research

---

* Substances include alcohol, marijuana, illicit drugs, and prescription drugs. The term *substance misuse* replaces the term *substance abuse* and refers to risky (i.e., binge use), hazardous, and harmful use of substances. Individuals engaged in substance misuse are at increased risk for experiencing negative effects of their substance-using behavior.

Contents

Background

Reducing the problematic use of alcohol and other drugs is at the forefront of a global and national health policy agenda and represents one of the American Academy of Social Work and Social Welfare (AASWSW) Grand Challenges for Social Work (Begun & DiNitto, 2017). Unhealthy alcohol use is a well-established risk factor for heightened morbidity and mortality and is linked to a host of social and economic problems (Centers for Disease Control and Prevention [CDC], 2018a; World Health Organization [WHO], 2014). In the United States, alcohol use is common. According to the National Survey on Drug Use and Health (NSDUH), 57.1% of young adults aged 18–25 reported using alcohol in 2016 (i.e., drank alcohol in the past month), which corresponds to about 19.8 million individuals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Among adults aged 26 and older, 54.6% reported current alcohol use, approximately 114.7 million adults (SAMHSA, 2017).

According to the CDC (2018a), excessive alcohol use includes heavy drinking, binge drinking, and any drinking by pregnant women or individuals under 21 years of age. The National Institute of Alcohol Abuse and Alcoholism (NIAAA, 2016) defines heavy drinking for men as consuming 15 or more drinks per week and for women and adults 65 and older, 8 drinks or more per week. Binge drinking is defined as five or more drinks for men and four or more drinks for women, which results in a blood alcohol level of 0.08 g/dL (the legal limit for adults) within a 2-hour timespan (NIAAA, 2016). Excessive drinking is pervasive in the United States: According to the 2016 NSDUH, among 136.7 million persons aged 12 and older who used alcohol, almost half (47.8%) engaged in binge drinking and 11.9% engaged in heavy alcohol use (SAMHSA, 2017).

The physical health consequences of excessive alcohol use include a multitude of short- and long-term adverse effects that increase the likelihood of injury and early death. In addition to heightened risk of developing an alcohol use disorder, health problems include damage to numerous organ systems, developmental disorders from fetal exposure, and diseases (e.g., cardiometabolic disorders and some types of cancer; Begun & DiNitto, 2017). Recent research conducted by the WHO (2014) has established a causal link between harmful alcohol use and infectious diseases, including tuberculosis and HIV/AIDS. According to the WHO (2014), alcohol use is responsible for approximately 5% of global disease burden, and nearly 6% of all deaths worldwide are attributed to alcohol consumption. In the United States approximately 88,000 persons die annually from alcohol-related causes, with almost one third (31%) of all motor vehicle deaths directly attributable to alcohol use (National Center for Statistics and Analysis, 2014). In the United States definitive research on actual causes of death in the year 2000 ranked alcohol as third, ahead of microbial agents, toxic agents, firearms, and use of all illicit drugs (Mokdad, Marks, Stroup, & Gerberding, 2004). This latter statistic has remained stable over time: According to the NIAAA (2016), alcohol was the third leading preventable cause of death in 2014.

In addition to serious health ramifications, alcohol use is linked to a host of behavioral, social, and economic problems (Begun & DiNitto, 2017). The direct and indirect costs (e.g., lost productivity) are staggering. Excessive alcohol consumption places an immense economic burden on the United States, costing an estimated $249.0 billion dollars in 2010, with the U.S. government covering $100.7 billion (40.4%) of the expense (Sacks, Gonzales, Bouchery, Tomedi, & Brewer, 2015). The median cost of alcohol use per state was $3.5 billion, with binge drinking accounting for more than 70% of the economic burden in all states. These latter costs remained steady since 2006, even during the economic recession from 2007 to 2009 (Sacks et al., 2015).

A recently released analysis of trend data collected with the National Epidemiologic Survey on Alcohol and Related Conditions showed significant increases in alcohol use, high-risk drinking, and alcohol use disorders in the U.S. general population and among certain subpopulations (i.e., older adults, women, and socioeconomically disadvantaged and minority groups) during the decade or so between 2001–2002 and 2012–2013 (Grant et al., 2017). Data from Monitoring the Future surveys suggest that trends for alcohol and drug use among adolescents are encouraging, with rates of drug and alcohol use declining or remaining stable over the past two decades (National Institute on Drug Abuse [NIDA], 2018). These trends are consistent with youth drug use surveillance data collected by the CDC (n.d.) through the Youth Risk Behavior Survey. The one exception to this positive trend is an increase in electronic nicotine delivery system use, commonly known as vaping (Curran, Burk, Pitt, & Middleman, 2018). In addition, perception of harm related to marijuana use has recently trended downward, yet the perception of risk among 12th graders related to binge drinking has significantly increased (NIDA, 2018). Of concern to social workers are the increases in alcohol misuse among client groups that already experience disparities in health outcomes and inequitable access to health-care resources. It is notable that alcohol misuse (and its attendant negative health sequelae) increased, despite widespread availability of effective pharmacological and behavioral interventions (Grant et al., 2017); for example, medication-assisted treatment such as naltrexone coupled with psychosocial support for the treatment of alcohol use disorder. Thus, there is an urgent need for population-based, culturally responsive intervention approaches to prevent and reduce the at-risk use of alcohol.

According to the WHO (2018), the tobacco epidemic is one of the biggest public health threats the world has ever faced. The WHO (2018) estimates that tobacco use is responsible for 7 million deaths per year worldwide. Smoking, which is the leading cause of preventable disease in the United States, harms every major organ in the body and is directly linked to harmful secondary smoke exposure and deleterious birth outcomes (CDC, 2018b). Approximately 6 million deaths are the result of direct tobacco use, whereas the remainder is due to nonsmokers being exposed to second-hand smoke (WHO, 2018). Moreover, and of particular concern to social workers seeking to alleviate health disparities, smoking disproportionately affects low-income and minority populations. An estimated 80% of the 1.1 billion smokers worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is disproportionately experienced (WHO, 2018). Further, WHO (2018) data show that a substantial proportion is unaware of the specific risks associated with tobacco use, smoking, and exposure to secondary smoke. Here in the United

States in 2016, almost 32% of American Indians and Alaska Natives smoked cigarettes, as compared to approximately 16% of non-Hispanic Whites (CDC, 2018b). It is well established that individuals with psychiatric conditions (e.g., depression, anxiety) are more likely to smoke than those without mental disorders (Trosclair & Dube, 2010), a disparity that is even more marked among individuals with serious mental illnesses such as schizophrenia and bipolar disorder (Dickerson et al., 2018). On average, individuals who smoke die 10 years earlier than their nonsmoking counterparts (CDC, 2018b). Most individuals who smoke are aware of the dangers of smoking and express a desire to quit, and research shows that counseling and medication can more than double the likelihood of success among those who do try to quit (WHO, 2018). Consistent with 2008 U.S. Public Health Service Guidelines (*Treating Tobacco Use and Dependence*), the U.S. Preventive Services Task Force (USPSTF, 2015) endorses evidence-based approaches that include universal screening and behavioral interventions to prevent tobacco use and tobacco-related disease in adults, including pregnant women.

Misuse of prescription drugs and illicit drug use also are major public health problems. According to SAMHSA (2017), the number of persons engaged in illicit drug use increased from 8.1% of the U.S. population in 2008 to 10.6%, or 28.6 million individuals, in 2012. NSDUH data show that more than 20 million persons met diagnostic criteria for some type of substance use disorder (SUD) in 2016, which represents 7.5% of people aged 12 or older (SAMHSA, 2017). Clinical evidence suggests that the prevalence of SUDs presenting in primary care settings is much higher than that reported in the 2016 NSDUH. Using data from a large validation study of a substance use screening tool, Wu et al. (2017) found that more than one third (36.0%) of adult primary care patients had a diagnosable SUD. The majority had a moderate or severe SUD, underscoring the need to properly detect and address these disorders via provider training and enhanced integration of primary and specialized treatment services (Wu et al., 2017). Furthermore, among adolescent primary care patients, almost 15% in one study were found to have a substance use problem based on universal screening results (Knight et al., 2007).

The United States presently is besieged by an opioid crisis of unprecedented magnitude, and states are scrambling to meet the demands of this pervasive problem. The CDC (2016) estimated that daily, approximately 3,900 persons initiated nonmedical use of prescription opioids, and nearly 600 initiated heroin use. The current opioid epidemic comes with a heavy economic burden, costing an estimated $55 billion dollars annually (CDC, 2016). Recent research shows that drug overdose deaths in the United States continue to climb, with 6 of 10 overdose deaths directly linked to opioids (Rudd, Seth, David & Scholl, 2016). Since 1999 the frequency of overdose deaths (including prescription drugs and heroin) has quadrupled, with an estimated 91 persons dying each day in the United States from drug overdoses (CDC, 2016). Epidemic levels of fatalities have been reported, with more than half a million deaths attributable to drug overdose from 2000 through 2015 (CDC, 2016).

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

The human cost of problematic substance use is considerable, and social work practitioners see the consequences of substance misuse and substance use disorders (SUD) firsthand in hospitals, schools, shelters, correctional facilities, child welfare, and other practice settings. SBIRT is a promising, research-based approach for identifying at-risk alcohol and other substance use and intervening early on to prevent further development of substance-related problems (Agley et al., 2014; McPherson et al., 2018). SBIRT was developed specifically for practice settings wherein universal screening approaches could be broadly implemented to large populations (e.g., hospitals, emergency departments, primary care, mental health, schools). Hallmark features of SBIRT include universal prescreening and screening with brief, validated measures, followed by an immediate brief intervention and referral to specialized treatment, if needed. SBIRT incorporates motivational interviewing strategies to facilitate client-centered and positive, relationship building and to help clients explore and resolve ambivalence about changing substance-using behaviors. Brief interventions typically culminate in a contract that articulates the goals and strategies for reducing substance use and arrangements for follow up. For clients demonstrating a need for more in-depth assessment or specialized treatment, SBIRT emphasizes warm handoffs (active, provider-initiated referrals) in lieu of passive referrals and specified protocols for facilitating interim communication and follow up.

In 2003, SAMHSA launched the largest SBIRT dissemination effort ever undertaken in the United States. The initial cohort included one tribal organization and six states tasked with promoting, integrating, and sustaining SBIRT in various medical settings (Aldridge, Linford, & Bray, 2017). To facilitate further implementation and dissemination of SBIRT, SAMHSA provided multiyear awards in 2008–2009 to fund training programs for physicians and other medical professionals. In 2013, social workers were included in the SAMHSA SBIRT training program.

The bulk of SBIRT evaluations in the past decade have been undertaken in primary health-care settings and emergency departments (e.g., Agley et al., 2014; Babor et al., 2007); however, the model has been tested in numerous diverse settings, including jails (e.g., Begun, Rose, LeBel, & Teske-Young, 2009), college health centers (e.g., Borsari & Carey, 2000), schools (e.g., Curtis, McLellan, & Gabellini, 2014), and employee assistance programs (e.g., Osilla et al., 2010). In addition, the USPSTF (2018) recommends screening and brief behavioral counseling interventions for risky or hazardous drinking for adults and pregnant women in primary care settings. The effectiveness of screening and brief interventions in reducing alcohol consumption and improving general and mental health is well established (see, e.g., Babor et al., 2007; Bertholet, Daeppen, Wietlisbach, Fleming & Burnand, 2005; Cheripitel, Moskalewicz, Swiatkiewics, Ye, & Bond, 2009; Madras et al., 2009). At present, the research examining the SBIRT model for reducing illicit drug use is promising, but inconclusive, with studies yielding somewhat inconsistent results across providers,

patient populations, and settings (Glass et al., 2015; Gryczynski et al., 2011; SAMHSA, 2011; Simioni, Rolland, & Cottencin, 2015; Young et al., 2012). Babor, Del Boca, and Bray (2017) conducted a cross-site, multimethod evaluation of 11 SAMHSA-funded SBIRT programs that screened more than 1 million people for SUD in a variety of medical and community settings. Results showed that SBIRT processes yielded clinically and statistically significant posttest differences on almost every measure of substance use, with greater intervention intensity associated with larger reductions in substance use (Babor et al., 2017). Aldridge, Dowd, and Bray's (2017) large-sample study showed that brief treatment (i.e., multiple sessions) was similar to brief intervention for reducing alcohol use and marijuana use, but brief treatment had a greater impact than brief intervention on reducing illicit drug use. These latter results are consistent with an earlier, smaller scale trial that demonstrated the efficacy of screening and brief intervention for reducing marijuana use and promoting abstinence among adolescent and young adult emergency department patients (Bernstein et al., 2009). The USPSTF (2018) has concluded that at this time there is insufficient evidence to determine the benefits versus the harms of adolescent screening and brief behavioral counseling for alcohol use in primary care. The American Academy of Pediatrics (2016) recommends that pediatricians increase their ability to detect, assess, and intervene with adolescent substance use while gaining familiarity with SBIRT and adolescents (e.g., Levy & Shrier, 2015). Risk factors that influence adolescents trying drugs include drug availability in their communities; family environmental factors such as violence, mental illness, and drug use in their households; and genetic vulnerability (NIDA, 2014). Preventing and reducing harms of adolescent substance use include developmental prevention interventions targeting the onset of harmful patterns of use, universal strategies to minimize the attractiveness of use, and regulatory interventions such as reducing availability (Toumbourou et al., 2007). As the SBIRT model expands, research is needed to identify the preferred service mix for clients with disparate levels of substance use (Gryczynski et al., 2011), and additional studies on SBIRT and adolescents are needed.

The USPSTF (2015) endorses the use of universal screening to identify tobacco users and engage them in tobacco (smoking) cessation discussions. Evidence of the effectiveness of screening and brief counseling interventions for tobacco use and smoking is mixed but accumulating, with the bulk of feasibility and pilot studies conducted in emergency department and primary health-care settings (e.g., Boudreaux, Abar, Haskins, Bauman, & Grissom, 2015; Land et al., 2012). A pilot study of SBIRT with persons living with HIV who currently smoked cigarettes showed reductions on all smoking outcome measures, even among those not ready to quit at baseline, providing preliminary support for the integration of the SBIRT model in HIV/AIDS clinic settings (Cropsey et al., 2013).

The SBIRT approach has been adapted for identification and treatment of depression, anxiety, and trauma, conditions that are prevalent among primary care patients (SAMHSA, 2011). Evidence of the effectiveness of screening and brief interventions with these latter behavioral health problems is scant but accumulating. For example, a recent trial in a pediatric primary care setting indicated that embedding behavioral health consultants increased treatment initiation among adolescents referred for psychiatric and SUD treatment services (Sterling et al., 2017). Using a quasi-experimental design, Dwinnells (2015) found that SBIRT was effective in identifying outpatient clinic patients at risk for

depression and problematic substance use and facilitating referrals for those at increased risk. In a recent review of best practices for managing generalized anxiety disorder and panic disorder in adults, Locke, Kirst, and Schultz (2015) emphasized the appropriateness of brief screening, patient education, and cognitive-behavior therapy in clinical settings. Topitzes et al. (2017) combined SBIRT with a model designed to address trauma (T-SBIRT) with a sample of low-income minority patients and assessed multiple indicators of feasibility. Results indicated that the T-SBIRT approach was associated with high referral acceptance rates, underscoring its suitability for diverse community health patients with probable alcohol use disorders (Topitzes et al., 2017). In sum, translational research is needed to determine whether SBIRT components can be used to effectively address symptoms of depression, anxiety, and trauma in health-care settings.

Computer technologies have become increasingly prominent in SBIRT implementation across settings and patient populations. The electronic health record (EHR), for example, can facilitate the efficient exchange of health information (e.g., screening data) for high-risk patients needing treatment for chronic and comorbid primaryand behavioral health conditions (Wu et al., 2016). The efficient and effective integration of SBIRT and other behavioral health interventions in health-care settings can be facilitated by the use of a variety of technologies, such as computerization of screening tools embedded into the EHR (e.g., Lee et al., 2015; McNeely, Strauss, Rotrosen, Ramauter, & Gourevistch, 2016; Spear, Shedlin, Gilberti, Fiellin, & McNeely, 2016), computerized delivery of physician-assisted and self-guided brief interventions (e.g., Schwartz et al., 2014), and integration of EHR clinical decision-support tools into the clinic workflow (Wamsley et al., 2016). Evidence of the effectiveness of computer-based approaches to screening and brief intervention is accumulating (Dwinnells & Misik, 2017), with research showing that self-administered computer screening is valid for and often preferred by adolescent patients, in particular (e.g., D'Souza & Harris, 2016; Harris et al., 2016). As technological innovations with SBIRT continue to gain traction in diverse health-care settings, it is important for providers to consider and assess issues of feasibility and client knowledge of and comfort with computer-based applications.

Finally, cost-effectiveness analyses of SBIRT have yielded positive results, underscoring its value for benefitting many clients at considerable economic savings (Barbosa et al., 2017; Quanbeck, Lang, Enami, & Brown, 2010; Solberg, Maciosek, & Edwards, 2008). Babor et al.'s (2017) large-scale evaluation showed that SBIRT implementation was associated with treatment system equity and efficiency. These latter authors ultimately referred to SBIRT as a major scientific accomplishment that translates research into health policy and clinical practice.

Social Work and SBIRT

S tandards recently published by the National Association of Social Workers (NASW, 2013) affirm an expanded role for professional social workers in the prevention and treatment of SUD via research-informed methods that are consistent with contextualized practice and the profession's core values. The NASW (2013) practice standards acknowledge emerging issues that shape responses to and interventions for client systems affected by problematic substance use and SUDs, such as widespread recognition of the pervasiveness of SUDs in nonspecialized treatment settings, the growth of integrated health-care arrangements, and broader acceptance of harm reduction strategies. Large numbers of social workers are employed in specialized treatment settings that serve clients with SUD and those experiencing co-occurring substance use and mental disorders (Begun & DiNitto, 2017). However, many social work practitioners provide services to individuals and families in settings where substance misuse is an important component of the presenting problem (e.g., criminal justice, child welfare, veteran's programs, aging, and hospital settings; NASW, 2013).

Anchored in scientific evidence and consistent with a client-centered, strengths-oriented philosophy, SBIRT positions social workers to respond to individuals at risk of developing SUD with a stance that is entirely consistent with the profession's core practice principles and values (self-determination, competence, cultural humility, respect, interdisciplinary and interorganizational collaboration, and advocacy). Although the evidence base for SBIRT is rooted in primary care and other health settings (Babor et al., 2007), the SBIRT intervention approach generally has been embraced by social work scholars and clinicians as a practical tool for practitioners, administrators, and educators to address substance misuse and SUD among vulnerable and at-risk populations receiving services in a variety of health and social service settings (Bliss & Pecukonis, 2009).

Published evaluations of SBIRT training undertaken with social work students were scarce prior to 2015 (e.g., Osborne & Benner, 2012). However, SAMHSA funding has enabled social work programs to implement and test an array of pedagogically diverse SBIRT training programs across the country (e.g., Senreich, Ogden, & Greenberg, 2017a, 2017b). A 2017 special issue of the *Journal of Social Work Practice in the Addictions,* Implementing the Grand Challenge of Reducing and Preventing Alcohol Misuse and its Consequences, which was reprinted as a book (Begun & DiNitto, 2018), recently published many evaluation studies of these pilot programs (see, e.g., Carlson et al., 2017; Putney, O'Brien, Collin, & Levine, 2017; Sacco et al., 2017). Evaluation results are encouraging, with the corpus of findings generally indicating positive posttraining changes in students' knowledge, attitudes, self-efficacy, and practice behaviors. Additional SBIRT training evaluations are available in a 2019 special issue of the *Journal of Social Work Practice in the Addictions*.

Social work educators recognize that having an adequately prepared workforce is a prerequisite for widespread SBIRT implementation and dissemination (Ogden, Vinjamuri, & Kahn, 2016). Thus,

researchers have sought to identify strategies that are responsive to unique population and setting characteristics, thereby addressing critical translational issues that may foster greater dissemination and uptake of SBIRT in field (Putney et al., 2017) and professional practice settings (Berger, Hernandez-Meier, Hyatt, & Brondino, 2017). By incorporating SBIRT practice into the repertoire of evidence-informed approaches for persons affected by substance misuse and SUDs, "social workers can markedly improve treatment services for clients and their families" (NASW, 2013; p. 6).

In the past decade the Council on Social Work Education (CSWE) has demonstrated its commitment to this critical public health imperative. With support from SAMHSA, the CSWE (2008) published *Advancing Social Work Practice in the Prevention of Substance Use Disorders*, which presented knowledge and practice behaviors linked to each of the competencies (as stipulated by the 2008 Educational Policy and Accreditation Standards) necessary for effective practice in the prevention of substance use disorders. The present mapping analysis expands on and extends some of the key principles articulated by the earlier 2008 CSWE document, providing a competency-based approach for infusing SBIRT content into undergraduate and graduate social work curricula.

Competency 1 Demonstrate Ethical and Professional Behavior

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Screening brief intervention and referral to treatment (SBIRT) practice is consistent with the value base of the social work profession. The foundation of the SBIRT model is rooted in the importance of understanding and integrating each individual's unique values and perspectives about alcohol, tobacco, and other substances into the assessment and intervention process. SBIRT curricula teach nonstigmatizing language and collaborative approaches for assessing and intervening with individuals who present with at-risk alcohol and other substance use. The SBIRT approach is client centered in that it honors the self-determination of individuals and eschews moralizing responses to individuals who drink and use other drugs.

SBIRT provides a public health framework for collaboratively working as part of interdisciplinary teams. SBIRT also provides a shared language and approach for assessing and intervening with diverse clients and clients' constituents. The SBIRT approach can be used by individuals from different professions and can be implemented so that teams of health-care providers work together in a coordinated manner. SBIRT is a flexible and evolving intervention that can be implemented with or without technological aids such as iPads (for computer-delivered and computer-guided therapist-delivered assessment and brief interventions), and it is being adapted and tested as a framework for addressing various health issues (e.g., substance use disorders, trauma, health promotion) in integrated health settings.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- demonstrate awareness of how their personal values may influence the way that they understand and subsequently screen for and assess alcohol and other drug use with diverse populations,

- demonstrate the knowledge and skills to screen for alcohol and other drug use consistent with the core values of the profession and seek supervision and consultation when needed,

- understand the evidence base of SBIRT and its contribution to intervention knowledge in the area of substance use,

- recognize that the SBIRT model is consistent with interdisciplinary practice in integrated health settings,

- demonstrate professionalism and adherence to the NASW Code of Ethics and other local laws and regulations when delivering SBIRT, and

- demonstrate understanding and ability to ethically use technology when providing, documenting, and evaluating SBIRT.

Competency 2 Engage Diversity and Difference in Practice

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Practitioners engaged in SBIRT activities understand the impact of discrimination and oppression and how they manifest in health disparities for minority and oppressed populations. This includes populations with inadequate access to health-care resources who are at disproportionate risk of experiencing the negative impact of substance misuse, substance use disorders (SUD), and other behavioral health conditions. SBIRT practitioners identify the intersectionality of multiple characteristics of diversity and difference with respect to overall health and well-being and access to appropriate whole-person health care. In addition, social work practitioners engaged in SBIRT activities are grounded in a recovery-oriented paradigm and understand how stigma serves as a barrier to proper identification and treatment of substance misuse and SUD.

SBIRT practitioners understand how stigma influences individuals' willingness to disclose their substance-using behaviors to health-care professionals and how it can affect primary health-care providers' inclination and ability to treat SUD as chronic health conditions. Social workers therefore advocate for health-care equity, the worth of each person, and a person-in-environment strength-based perspective in current and evolving health-care delivery systems. SBIRT essentially is client directed, and practitioners engaged in SBIRT activities understand that it is responsive to individual differences and preferences. SBIRT practitioners respect diversity and difference by incorporating a professional stance consistent with the spirit and principles of motivational interviewing, managing personal biases, interacting with cultural humility, and preserving the centrality of client-centered relationships.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- understand the influence of multiple factors that may affect the development of SUD, help-seeking behaviors, and formal and informal responses to substance misuse and SUD at the micro, mezzo, and macro levels;

- can match the continuum of client needs and preferences with appropriate continuum of care options;

- present themselves as life-long learners, applying self-awareness to manage the influence of personal biases through cultural humility in establishing partnerships with diverse clients and their constituents affected by substance misuse and SUD; and

- communicate the impact of structural inequalities on and the importance of diversity among at-risk clients and clients' constituents in their roles as health-care advocates and as members of interdisciplinary health-care teams.

Competency 3 Advance Human Rights and Social, Economic, and Environmental Justice

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Substance misuse and SUD greatly affect individuals, families, organizations, communities, and nations, and the direct and indirect human, social, and economic costs are staggering. Social workers understand that SBIRT is a cost-effective approach to addressing these issues. Social workers are knowledgeable about the disproportionate disease burden of SUD and other behavioral health disorders among oppressed, marginalized, and minority populations and are committed to expanding knowledge about the social determinants of health. Such knowledge is then directed at advocating for human rights and health equity at the micro, mezzo, and macro levels. Social workers understand that the presence and perpetuation of long-standing health disparities, with specific regard to health outcomes and access to proper health care, is a major social welfare and public health concern. Social workers promote, implement, and evaluate SBIRT interventions to advance whole-person health and ensure that health-care resources, including specialized SUD-related treatment services, are properly and equitably distributed when referring to treatment. Practitioners engaged in SBIRT activities work to advance human rights and social and economic justice for clients who struggle with multiple chronic conditions and face structural and other barriers when attempting to access needed health-care services.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- recognize that health care is a human right and seek opportunities to educate diverse clients, clients' constituents, and health-care providers about the treatable nature of SUDs and other behavioral health conditions;

- understand the complex social, economic, and environmental contexts of health-care delivery systems and apply knowledge about the social determinants of health to ensure that health-care resources, including scarce specialized treatment services and recovery supports, are properly and equitably distributed;

- participate in system changes at all levels to correct negative public perceptions and provider stereotypes about SUD and other behavioral health conditions and redress social, economic, and environmental injustices that render certain populations more vulnerable to the multiple impacts of substance misuse and SUD, such as individuals involved with the criminal justice system, pregnant and parenting women, persons with co-occurring mental disorders, youths, and older adults; and

- advocate for policy change at the local, state, regional, and national levels to promote SBIRT adoption, fidelity to the SBIRT model, and standards for SBIRT practice.

Competency 4 Engage in Practice-informed Research and Research-informed Practice

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

SBIRT practitioners benefit from the evidence base of an empirically validated intervention. Practitioners engaged in SBIRT practice often work in integrated care settings and, as members of interprofessional teams, they promote the translation of SBIRT research findings into diverse health and social service settings.

SBIRT practitioners understand that evidence for this approach is strongest in areas such as alcohol use in primary care settings and in emergency departments. They also recognize the practice contexts where there is currently limited evidence, such as SBIRT with adolescents and youths, persons with cognitive impairments, and when working with individuals who use substances other than alcohol. In addition to fully understanding the state of knowledge, social workers are cognizant of clinically and contextually relevant factors for which evidence is limited, and they recognize the need for evaluating their practice when adapting SBIRT with other populations such as older adults and members of underserved minority populations.

Practitioners engaged in SBIRT activities appraise the relevant quantitative and qualitative research and value their role in contributing to the knowledge base. SBIRT practitioners are consumers of multidisciplinary SBIRT research and review findings within the context of social work professional values. In addition to current evidence, social work practitioners understand areas in which SBIRT implementation might be logical and practical. They demonstrate understanding of steps that can be taken to evaluate SBIRT in practice, such as monitoring SBIRT use in practice and relevant outcomes for clients. For instance, in a new clinical setting, social workers will track the delivery of screenings and evaluate the fidelity of brief interventions and referrals to treatment. SBIRT practitioners can articulate different methods of determining how SBIRT interventions precipitate changes in alcohol and other drug use among clients.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- assess the SBIRT research evidence for best practice fit and demonstrate knowledge of the current state of evidence for SBIRT, including limitations for different substances, contexts, and populations;

- apply critical thinking to understand where logical and practical adaptation of the SBIRT intervention can take place and collaborate with professionals from other disciplines and organizations to implement SBIRT services;

- demonstrate knowledge of relevant processes and outcomes to consider when evaluating SBIRT and share practice knowledge with SBIRT researchers to advance knowledge;

- perform research that sheds light on service delivery system factors that influence SBIRT outcomes;

- systematically observe the implementation of SBIRT to study barriers and facilitators and build practice knowledge, including cultural considerations;

- promote the adoption, implementation, and evaluation of SBIRT and other related evidence-based practices such as medication-assisted treatment;

- advocate for policy change at the local, state, regional, and national levels to promote SBIRT adoption; and

- engage in research about best practices for training practitioners to implement SBIRT with fidelity to the model.

Competency 5 Engage in Policy Practice

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Practitioners engaged in SBIRT activities function effectively in increasingly integrated health-care environments and understand how policies at the local, state, national, and global levels influence the extent to which environments support individuals' health and well-being, including their vulnerability to and recovery from the pernicious effects of substance misuse and SUD. Social workers engaged in SBIRT practice assume policy practice roles by advocating for social and organizational policy changes that support person-centered care and the design and delivery of integrated health-care services. They also participate as leaders in systems-level change efforts to enhance coordination of SUD-related components of care. SBIRT policy-practitioners are mindful of policies at different levels (e.g., 42 *Code of Federal Regulations* Part 2, Health Insurance Portability and Accountability Act) that affect their professional relationships in the as they help clients avoid developing SUD.

Social workers engaged in SBIRT practice have the knowledge and skills to engage coalitions and to assist organizations with developing and updating policies that promote implementation of evidence-based SBIRT practice with diverse clients, including policies that affect Medicaid, Medicare, and other third-party reimbursement of SBIRT.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- employ critical thinking to formulate, analyze, implement, and evaluate policies influencing evidence-based SBIRT practice at the micro, mezzo, and macro levels;

- advocate for policies at all levels to increase access to whole-person health care and enhance service delivery for those affected by substance misuse, SUD, and other behavioral health conditions;

- Identify and challenge policies across all levels, practice settings, and fields of practice that are counter to the spirit and principles of SBIRT and that present significant barriers to SBIRT implementation in practice;

- are at the forefront of health-care policy reform efforts that improve the health and well-being of individuals, families, communities, and organizations affected by substance misuse and SUDs, including the workforce;

- advocate for Medicaid, Medicare, and third-party coverage to promote SBIRT implementation by diverse health professionals; and

- have knowledge of the local, state, and federal policies and other barriers affecting equitable dissemination of and reimbursement for SBIRT services.

Competency 6 Engage With Individuals, Families, Groups, Organizations, and Communities

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Social work practitioners understand and apply specific motivational interviewing (MI) techniques and relevant theories (e.g., transtheoretical model of change, person-in-environment) to engage diverse clients in a dialogue about their use of alcohol and other substances. Social workers use effective communication skills such as open-ended questioning and reflective listening to build collaborative client–practitioner relationships and advance SBIRT practice with diverse individuals in diverse practice settings. Through SBIRT, and consistent with the spirit of MI, social workers foster conversations that are centered on the strengths, priorities, and self-identified concerns of the individuals with whom they work. Social workers are mindful of the heavily contextualized nature of SBIRT practice and understand how individuals are affected by and affect families, other influential groups, organizations, and communities. For example, social work practitioners who serve youths recognize the importance and bidirectional influence of the family, peer-group, and school contexts when engaging in SBIRT activities with adolescents. SBIRT practitioners recognize the centrality of human relationships when building rapport with diverse clients, clients' constituents, and other health-care professionals. While implementing SBIRT interventions, social workers understand how their own personal experiences and affective reactions may affect their ability to effectively engage with client systems at the individual, family, group, organization, and community levels. Social workers who provide SBIRT services value and promote interprofessional training and collaboration that expands SBIRT capacity within professional groups, organizations, and communities, ultimately seeking to improve health outcomes for diverse client groups.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- use MI strategies to engage diverse clients and their constituents in the context of relevant family, group, organizational, and community-level factors;

- employ MI as a person-centered communication style for addressing personal ambivalence about change, using open-ended questions, affirmations, reflections, and summarizing skills;

- apply evidence-based tools, questions, and critical thinking to determine the client's level of motivation (e.g., readiness for change) during the SBIRT encounter and use empathy, core interviewing, and interpersonal skills to engage with the client accordingly;

- implement MI-informed principles of engagement at all system levels associated with SBIRT service delivery, including family, groups, organizations, and communities; and

- identify and engage with individuals in clients' social networks who support clients' change efforts.

Competency 7   Assess Individuals, Families, Groups, Organizations, and Communities

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Social workers using SBIRT understand the interactive process of practice that includes screening for alcohol, tobacco, and other drug use. The SBIRT process distinguishes between screening and assessment activities. SBIRT screening employs short, reliable, and valid screening tools that are strengths-based, seeking to empower clients based on their personal accounts by using MI as a supportive skill set. Assessment in SBIRT, which may occur in either generalist of specialty treatment settings, is a distinct activity undertaken with individuals who screen positive for at-risk, hazardous, or harmful substance use. The assessment process is collaborative and dynamic in SBIRT. In partnership with the client, the assessment process yields a comprehensive, strengths-based, and contextualized understanding of the impact of substance use on the client system, including barriers to and motivation and resources for changing substance-using behavior. SBIRT practitioners understand the importance of a nonjudgmental and conversational approach with all individuals, and with those who may have a history of substance misuse or SUD, in particular. Practitioners respond affirmatively and proactively to individuals whose screening results indicate that they do not currently have a problem, advising them what to do if the situation changes.

Social workers engaged in SBIRT understand that the screening and assessment processes work well within a stages-of-change framework by helping individuals develop mutually approved intervention goals and objectives based on their values and needs. Social work practitioners engaged in SBIRT activities understand the contextual factors at the group, organizational, and community levels that affect clients' comfort level with screening approaches and methods. SBIRT practitioners also demonstrate up-to-date knowledge about innovative, ongoing, culturally relevant research in other health and allied health areas for adults and adolescents. Social worker practitioners engaged in SBIRT activities understand that multidiscipline environments are ideal settings for conducting screening activities, recognizing, as part of the SBIRT process, the importance of interprofessional collaboration for addressing the substance use concerns and behaviors of clients.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- demonstrate knowledge of reliable and empirically validated substance use screening tools and their applicability to specific substances and populations;

- appropriately and systematically use substance use and other relevant screening tools with adolescents and adults in diverse health settings to identify and address unmet client needs;

- demonstrate knowledge of the SBIRT process in the development of collaborative intervention goals that address the values of the client, based on screening results;

- demonstrate knowledge of relevant interprofessional environments conducive to SBIRT screening;

- recognize the ongoing and dynamic nature of a more in-depth multidimensional assessment, an iterative process that allows for periodic reevaluation of changes in clients' circumstances and conditions over time; and

- employ self-awareness and critical thinking skills when using and applying the results of screening and assessment activities to best serve clients.

Competency 8 Intervene With Individuals, Families, Groups, Organizations, and Communities

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

SBIRT is a set of practice behaviors developed for early identification of and intervention with individuals engaged in or at risk of problematic alcohol use. Practitioners engaged in SBIRT activities are cognizant of the accumulated evidence supporting the use of screening and brief intervention (SBI) for alcohol use and understand that SBI requires interprofessional collaboration to produce beneficial client outcomes. Social workers often serve client populations with unmet health-care needs who are disproportionately vulnerable to the negative consequences of substance misuse, but who also experience numerous barriers to specialized prevention or treatment services that specifically target mental, substance use, and co-occurring disorders. The brief intervention component of SBIRT, which incorporates person-centered MI skills, facilitates the identification of practice goals and values that enhance the capacities of clients and their constituents.

The brief intervention component of SBIRT has been demonstrated to reduce tobacco use, alcohol consumption, and binge drinking among diverse populations seeking treatment in health care and other settings. SBIRT projects have shown promising results for reducing risky drug use (e.g., marijuana, cocaine, heroin) and identifying and treating depression, anxiety, and trauma. When implementing brief interventions, social work practitioners follow a research-supported algorithm that guides clients through behavior change, with the goal of preventing more severe consequences of substance-using behavior. The brief intervention component of SBIRT is efficient in terms of time use, and it has strong potential to benefit a large number of clients whose needs might otherwise go unmet. SBIRT activities have promising potential to expand the current repertoire of brief interventions, in keeping with social work practice principals of client-centered care that are used and tested by health professionals in diverse organizational and community-based settings.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- seek to mitigate the disproportionately negative impact of substance-using behaviors on the health and well-being of disadvantaged and vulnerable individuals and their families;

- employ MI knowledge and skills to effectively listen and negotiate mutually approved goals with clients;

- use communication skills and a therapeutic stance rooted in MI to provide timely individualized assessment feedback as part of the intervention process while supporting client goals, strengths, and values;

- implement and evaluate culturally responsive brief interventions with clients, using health data collected with short, reliable, and valid substance use screening tools;

- engage in ongoing professional education to promote critical thinking about culturally relevant application of the SBIRT intervention model to individuals engaged in at-risk use of substances other than alcohol;

- understand and demonstrate knowledge of the importance of interprofessional SBIRT collaboration and communication, within and across organizations, for facilitating optimal client outcomes;

- demonstrate organizational- and community-level knowledge and skills when referring clients for more intensive intervention when such a need is indicated;

- employ critical thinking skills to analyze SBIRT knowledge garnered through evaluation to enhance practice; and

- seek to mitigate the socioeconomic costs of substance misuse and SUD at the group, organizational, and societal levels.

Competency 9 Evaluate Practice With Individuals, Families, Groups, Organizations, and Communities

SPECIALIZED PRACTICE COMPETENCY DESCRIPTION

Practitioners engaged in SBIRT care understand that quality assurance and the evaluation of effectiveness, and practice outcomes are essential elements of practice with individuals, families, groups, organizations, and communities. Practitioners engaged in SBIRT critically select and systematically use quantitative and qualitative evaluation approaches as appropriate to gather data evaluating SBIRT screening, intervention, referral to treatment, and follow-up processes and outcomes that inform and enhance practice.

As critical consumers of relevant SBIRT research and evaluation findings disseminated by collaborative health-care professionals engaged in SBIRT practice, social workers must add to the SBIRT evaluation knowledge base and apply knowledge to improve SBIRT practice effectiveness at the micro, mezzo, and macro levels.

COMPETENCY BEHAVIORS

Practitioners engaged in SBIRT

- use appropriate validated screening and assessment tools to collect data on alcohol and other substance use;

- re-administer screening and assessment measures on a regular basis to monitor client progress;

- engage in SBIRT intervention fidelity checks to ensure effective practice;

- implement brief interventions in accordance with research-supported algorithms and frameworks and the perspectives of diverse groups of clients;

- routinely collect data on the status of referrals to treatment, including success in initial contact, engagement, and successful completion of services;

- collect implementation data for quality assurance using appropriate quantitative and qualitative approaches that incorporate the perspectives of clients;

- monitor implementation data to ensure SBIRT services are consistently delivered;

- use implementation data to improve the delivery of SBIRT services;

- systematically collect and analyze feedback, implementation, and progress data and use results to   inform and improve practice;

- critically review SBIRT outcome evaluations; and

- disseminate findings to stakeholders in the larger practice community.

References

Agley, J., McIntire, R., DeSalle, M., Tidd, D., Wolf, & Bassman, R. (2014). Connecting patients to services: Screening, brief intervention and referral to treatment in primary health care. *Drugs: Education, Prevention and Policy, 21*, 370–379.

Aldridge, A., Dowd, W., & Bray, J. (2017). The relative impact of brief treatment versus brief intervention in primary health-care screening programs for substance use disorders. *Addiction, 112* (Suppl. 2), 54–64.

Aldridge, A., Linford, R., & Bray, J. W. (2017). Substance use outcomes of patients served by a large U.S. implementation of screening, brief intervention and referral to treatment (SBIRT). *Addiction, 112* (Suppl. 2), 43–53.

American Academy of Pediatrics. (2016). Substance use screening, brief intervention, and referral to treatment: Committee on substance use and prevention policy statement. *Pediatrics, 138*(1). doi:10.1542/peds.2016-1210

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K., & Bray, J. (2007). Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse, 28*, 7–30, doi:10.1300/J465v28n03_03

Babor, T. F., Del Boca, F., & Bray, J. W. (2017). Screening, brief intervention and referral to treatment: Implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction, 112* (Suppl. 2), 110–117.

Barbosa, C., Cowell, A., Dowd, W., Landwehr, J., Aldridge, A., & Bray, J. W. (2017). The cost-effectiveness of brief intervention versus brief treatment of screening, brief intervention and referral to treatment (SBIRT) in the United States. *Addiction, 112* (Suppl. 2), 73–81.

Begun, A. L., & DiNitto, D. M. (Eds.). (2018). *Implementing the grand challenge of reducing and preventing alcohol misuse and its consequences*. London, UK: Routledge.

Begun, A. L., & DiNitto, D. M. (2017). Introduction to the special issue: Implementing the grand challenge of reducing and preventing alcohol misuse and its consequences. *Journal of Social Work Practice in the Addictions, 17*(1–2), 1–9. doi:10.1080/1533256X.2017.1301761

Begun, A. L., Rose, S. J., LeBel, T. P., & Teske-Young, B. A. (2009). Implementing substance abuse screening and brief motivational intervention with women in jail. *Journal of Social Work Practices in the Addictions, 9*, 113–131.

Berger, L., Hernandez-Meier, J., Hyatt, J., & Brondino, M. (2017). Referral to treatment for hospitalized medical patients with an alcohol use disorder: A proof-of-concept brief intervention study. *Social Work in Health Care, 56,* 321–334.

Bernstein, E., Edwards, E., Dorfman, D., Heeren, T., Bliss, C., & Bernstein, J. (2009). Screening and brief intervention to reduce marijuana use among youths and young adults in a pediatric emergency department. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine, 16*, 1174–1185. doi:10.1111/j.1553-2712.2009.00490.x

Bertholet, N., Daeppen, J., Wietlisbach, V., Fleming, M. F., & Burnand, B. (2005). Reduction of alcohol consumption by brief alcohol intervention in primary care: Systematic review and meta-analysis. *Archives of Internal Medicine, 165*, 986–995.

Bliss, D. L., & Pecukonis, E. (2009). Screening and brief intervention practice model for social workers in non-substance-abuse practice settings. *Journal of Social Work Practice in the Addictions, 9*, 21–41.

Borsari, B., & Carey, K. B. (2000). Effects of a brief motivational intervention with college students. *Journal of Consulting and Clinical Psychology, 68*, 728–733.

Boudreaux, E. D., Abar, B., Haskins, B., Bauman, B., & Grissom, G. (2015). Health evaluation and referral assistant: A randomized controlled trial to improve smoking cessation among emergency department patients. *Addiction Science and Clinical Practice, 10*, 2–10.

Carlson, J. M., Agley, J., Gassman, R. A., McNelis, A. M., Schwindt, R. … Khaja, K. (2017). Effects and durability of an SBIRT training curriculum for first-year MSW students. *Journal of Social Work Practice in the Addictions, 17*(1–2), 135–149. doi:10.1080/1533256X.2017.1304946

Centers for Disease Control and Prevention (CDC). (2018a). *Fact sheets: Alcohol use and your health*. Retrieved from https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

Centers for Disease Control and Prevention (CDC). (2018b). *Smoking and tobacco use: Fast facts*. Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm

Centers for Disease Control and Prevention (CDC). (2016). *Wide-ranging online data for epidemiologic research (WONDER)*. Atlanta, GA: CDC: National Center for Health Statistics. Retrieved from http://wonder.cdc.gov

Centers for Disease Control and Prevention (CDC). (n.d.). Youth risk behavior survey: Data summary & trends report 2007–2017. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf

Cheripitel, C. J., Moskalewicz, J., Swiatkiewics, G., Ye, Y., & Bond, J. (2009). Screening, brief intervention, and referral to treatment (SBIRT) in a Polish emergency department: Three-month outcomes of a randomized, controlled clinical trial. *Journal of Studies on Alcohol and Drugs, 70*, 982–990.

Council on Social Work Education. (2008). *Advancing social work practice in the prevention of substance use disorders*. Alexandria, VA: Author.

Cropsey, K. L., Hendricks, P. S., Jardin, B., Clark, C. B., Katiyar, N., Willig, J., … Carpenter, M. J. (2013). A pilot study of screening, brief intervention, and referral for treatment (SBIRT) in non-treatment seeking smokers with HIV. *Addictive Behaviors*, *38*, 2541–2546. doi:10.1016/j.addbeh.2013.05.003

Curran, K. A., Burk, T., Pitt, P. D., & Middleman, A. B. (2018). Trends and substance use associations with E-cigarette use in US adolescents. *Clinical Pediatrics, 57*, 1191–1198. doi:10.1177/0009922818769405

Curtis, L., McLellan, T., & Gabellini, N. (2014). Translating SBIRT to public school settings: An initial test of feasibility. *Journal of Substance Abuse Treatment, 46*, 15–21.

Dickerson, F., Schroeder, J., Katsafanas, E., Khushalani, S., Origoni, A. E. … Yolken, R. H. (2018). Cigarette smoking by patients with serious mental illness, 1999–2016: An increasing disparity. *Psychiatric Services, 69,* 147–153, doi:10.1176/appi.ps.201700118

D'Souza-Li, L., & Harris, S. K. (2016). The future of screening, brief intervention and referral to treatment in adolescent primary care: Research directions and dissemination challenges. *Current Opinion in Pediatrics, 28*, 434–440.

Dwinnells, R. (2015). SBIRT as a vital sign for behavioral health identification, diagnosis, and referral in community health care. *Annals of Family Medicine, 13,* 261–263.

Dwinnells, R., & Misik, L. (2017). An integrative behavioral health care model using automated SBIRT and care coordination in community health care. *Journal of Primary Care and Community Health, 8*, 300–304.

Glass, J. E., Hamilton, A. M., Powell, B. J., Perron, B. E., & Brown, R. T., & Ilgen, M. A. (2015). Specialty substance use disorder services following brief alcohol intervention: A meta-analysis of randomized controlled trials. *Addiction, 110*, 1404–1415.

Grant, B. F., Chou, S. P., Saha, T. D, Pickering, R. P., Kerridge, B. T. … Hasin, D. H. (2017). Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV alcohol use disorder in the United States, 2001–2002 to 2012–2013: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry, 74*, 911–923. doi:10.1001/jamapsychiatry.2017.2161

Gryczynski, J., Mitchell, S. G., Peterson, T. R., Gonzales, A., Moseley, A., & Schwartz, R. P. (2011). The relationship between services delivered and substance use outcomes in New Mexico's screening, brief intervention, referral and treatment (SBIRT) Initiative. *Drug and Alcohol Dependence, 118*, 152–157.

Harris, S. K., Knight, J. R., Jr., Van Hook, S., Sherritt, L., Brooks, T. L. ... Saitz, R. (2016). Adolescent substance use screening in primary care: Validity of computer self-administered versus clinician-administered screening. *Substance Abuse, 37*, 197–203.

Knight, J. R., Harris, S. K., Sherritt, L., Van Hook, S., Lawrence, N., Brooks, T., ... Kulig, J. (2007). Prevalence of positive substance abuse screen results among adolescent primary care patients. *Archives of Pediatrics & Adolescent Medicine, 161*, 1035–1041. doi:10.1001/archpedi.161.11.1035

Land, T. G., Rigotti, N. A., Levy, D. E., Schilling, T., Warner, D., & Li, W. (2012). The effect of systematic clinical interventions with cigarette smokers on quit status and the rates of smoking-related primary care office visits. *PLoS ONE, 7*, e41649. doi:10.1371/journal.pone.0041649

Lee, D. C., Budney, A. J., Brunette, M. F., Hughes, J. R., Etter, J. F., & Stanger, C. (2015). Outcomes from a computer-assisted intervention simultaneously targeting cannabis and tobacco use. *Drug and Alcohol Dependence, 155*, 134–140. doi:10.1016/j.drugalcdep.2015.08.001

Levy, S., & Shrier, L. (2015). Adolescent SBIRT: Toolkit for providers. Retrieved from https://www.mcpap.com/pdf/S2BI%20Toolkit.pdf

Locke, A. B., Kirst, N., & Shultz, C. G. (2015). Diagnosis and management of generalized anxiety disorder and panic disorder in adults. *American Family Physician, 91*, 617–624.

Madras, B. K., Compton, W. M., Avula, D., Stegbauer, T., Stein, J. B., & Clark, H. W. (2009). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug and Alcohol Dependence, 99,* 280–295.

McNeely, J., Strauss, S. M., Rotrosen, J., Ramautar, A., & Gourevitch, M. N. (2016). Validation of an audio computer-assisted self-interview (ACASI) version of the alcohol, smoking and substance involvement screening test (ASSIST) in primary care patients. *Addiction, 111*, 233–244.

McPherson, T., Goplerud, E., Bauroth, S., Cohen, H., Joseph, H., ... & Noriega, D. (2018). *Learner's guide to adolescent screening, brief intervention and referral to treatment (SBIRT).* Bethesda, MD: NORC at the University of Chicago.

Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. *Journal of the American Medical Association. 291,* 1238–1245.

National Association of Social Workers (NASW). (2013). *NASW standards for social work practice with clients with substance use disorders.* Washington, DC: Author. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=ICxAggMy9CU%3D&portalid=0f

National Center for Statistics and Analysis (2014). *2014 crash data key findings (traffic safety facts crash stats.* Report No. DOT HS 812 219). Washington, DC: National Highway Traffic Safety Administration, 2015. Retrieved from https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812219

National Institute of Alcohol Abuse and Alcoholism (NIAAA). (2016). *Alcohol facts and statistics*. Retrieved from https://pubs.niaaa.nih.gov/publications/alcoholfacts&stats/AlcoholFacts&Stats.pdf

National Institute on Drug Abuse (NIDA). (2014). *Principles of adolescent substance use disorder treatment: A research-based guide*. Retrieved from https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction

National Institute on Drug Abuse (NIDA). (2018). *Monitoring the future survey: High school and youth trends*. Retrieved from https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends

Ogden, L. P., Vinjamuri, M., & Kahn, J. (2016). Translating "SBIRT" into social work practice: An empirically-based model. *Journal of Social Service Research, 42,* 425–441.

Osborne, V. A., & Benner, K. (2012). Utilizing screening, brief intervention, and referral to treatment: Teaching assessment of substance abuse. *American Journal of Public Health, 102*, e37–e38. doi:10.2105/AJPH.2011.300639

Osilla, K. C., Cruz, E., de la Miles, J. N. V., Zellmer, S., Watkins, K. … Marlatt, G. A.. (2010). Exploring productivity outcomes from a brief intervention for at-risk drinking in an employee assistance program. *Addictive Behaviors, 35*, 194–200.

Putney, J. M., O'Brien, K. H. M., Collin, C., & Levine, A. (2017) Evaluation of alcohol screening, brief intervention, and referral to treatment (SBIRT) training for social workers, *Journal of Social Work Practice in the Addictions, 17,* 169–187. doi:10.1080/1533256X.2017.1302884

Quanbeck, A., Lang, K., Enami, K., & Brown, R. L. (2010). A cost-benefit analysis of Wisconsin's screening, brief intervention, and referral to treatment program: Adding the employer's perspective. *Wisconsin Medical Journal, 109*, 9–14.

Rudd, R. A., Seth P., David F., & Scholl, L. (2016). Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *Morbidity and Mortality Weekly Report*. doi:10.15585/mmwr.mm6550e1.

Sacco, P., Ting, L., Crouch, T. B., Emery, L., Moreland, M. … DiClemente, C. (2017). SBIRT training in social work education: Evaluating change using standardized patient simulation. *Journal of Social Work Practice in the Addictions, 17,* 150–168. doi:10.1080/1533256X.2017.1302886

Sacks, J., Gonzales, K., Bouchery, E., Tomedi, L., & Brewer, R. (2015). 2010 national and state costs of excessive alcohol consumption. *American Journal of Preventive Medicine, 49,* e73–e79.

Schwartz, R. P., Gryczynski, J., Mitchell, S. G., Gonzales, A., Moseley, A. … O'Grady, K. E. (2014). Computerized versus in-person brief intervention for drug misuse: A randomized clinical trial. *Addiction, 109*, 1091–1098

Senreich, E., Ogden, L. P., & Greenberg, J. P. (2017a). Enhancing social work students' knowledge and attitudes regarding substance-using clients through SBIRT training. *Journal of Social Work Education, 53*, 260–275.

Senreich, E., Ogden, L. P., & Greenberg, J. P. (2017b). A post-graduation follow up of social work students trained in SBIRT: Rates of usage and perceptions of effectiveness. *Social Work in Health Care, 56,* 412–434.

Simioni N., Rolland B., & Cottencin O. (2015). Interventions for increasing alcohol treatment utilization among patients with alcohol use disorders from emergency departments: a systematic review. *Journal of Substance Abuse Treatment*, 58, 6–15.

Solberg, L., Maciosek, M. V., & Edwards, N. M. (2008). Primary care intervention to reduce alcohol misuse: Ranking its health impact and cost effectiveness. *American Journal of Preventive Medicine, 34,* 143–152. doi:10.1016/j.amepre.2007.09.035

Spear, S. E., Shedlin, M., Gilberti, B., Fiellin, M., & McNeely, J. (2016). Feasibility and acceptability of an audio computer-assisted self-interview version of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) in primary care patients. *Substance Abuse*, *37*, 299–305.

Sterling, S., Kline-Simon, A. H., Jones, A., Satre, D. D., Parthasarathy, S., & Weisner, C. (2017). Specialty addiction and psychiatry treatment initiation and engagement: Results from an SBIRT randomized trial in pediatrics. *Journal of Substance Abuse Treatment, 82*, 48–54. doi:10.1016/j.jsat.2017.09.005

Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). *Screening, brief intervention and referral to treatment (SBIRT) in behavioral healthcare*. Retrieved from https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

Topitzes, J., Berger, L., Otto-Salaj, L., Mersky, J. P., Weeks, F., & Ford, J. D. (2017). Complementing SBIRT for alcohol misuse with SBIRT for trauma: A feasibility study. *Journal of Social Work Practice in the Addictions, 17,* 188–215. doi:10.1080/1533256X.2017.1305392

Toumbourou, J. W., Stockwell, T., Neighbors, C., Marlatt, G. A., Sturge, J., & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *Lancet, 369*, 1391–1401. doi:10.1016/S0140-6736(07)60369-9

Trosclair, A., & Dube, S. R. (2010) Smoking among adults reporting lifetime depression, anxiety, anxiety with depression, and major depressive episode, United States, 2005–2006. *Addictive Behavior, 35*, 438–443.

U.S. Preventive Services Task Force (USPSTF). (2018). Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: U.S. Preventive Services Task Force recommendation statement. *JAMA, 320*, 1899–1909. doi:10.1001/jama.2018.16789

U. S. Preventive Services Task Force (USPSTF). (2015). *Tobacco smoking cessation in adults, including pregnant women*: *Behavioral and pharmacotherapy Interventions.* Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1

Wamsley, M. A., Steiger, S., Julian, K. A., Gleason, N., O'Sullivan, P.S. … Satterfield, J. M. (2016). Teaching residents screening, brief intervention, and referral to treatment (SBIRT) skills for alcohol use: Using chart-stimulated recall to assess curricular impact. *Substance Abuse, 37*, 419–426.

World Health Organization (WHO). (2014). *Global status report on alcohol and health 2014*. Retrieved from http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua+1

World Health Organization (WHO). (2018). *Tobacco: Facts sheet*. Retrieved from http://www.who.int/mediacentre/factsheets/fs339/en/

Wu, L.-T., Brady, K. T., Spratt, S. E., Dunham, A. A., Heidenfelder, B., Batch, B. C., … Ghitza, U. E. (2016). Using electronic health records data for substance use screening, brief intervention, and referral to treatment among adults with type 2 diabetes: Design of a National Drug Abuse Treatment Clinical Trials Network Study. *Contemporary Clinical Trials*, *46*, 30–38. doi:10.1016/j.cct.2015.11.009

Wu, L., McNeely, J., Subramaniam, G., Brady, K. T., Sharma, G. … Schwartz, R. P. (2017), DSM-5 substance use disorders among adult primary care patients: Results from a multisite study. *Drug and Alcohol Dependence, 179,* 42–46. doi:10.1016/j.drugalcdep.2017.05.048

Young, M. M., Stevens, A., Galipeau, J., Pirie, T., Garritty, C. … Moher, D. (2012). Effectiveness of brief interventions as part of the Screening, Brief Intervention and Referral to Treatment (SBIRT) model for reducing the nonmedical use of psychoactive substances: A systematic review. *Systematic Reviews, 3*, 1–22.