Brief Intervention and Social Work: A Primer for Practice and Policy

Gerald Cochran & Craig Field

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Most individuals in need of help for alcohol use disorders do not receive care. Screening and brief intervention (SBI) is an evidence-based practice for reducing at-risk drinking and alcohol-related risk behaviors. Health care reform sets the stage for a large expansion of SBI to individuals in the United States. Social workers have the opportunity to play an important role in helping establish SBI nationally, but they must become more involved in its delivery, educating new social workers with respect to SBI practice, and taking part in research to expand the field’s knowledge of this service.

Keywords: Screening and brief intervention, substance abuse, healthcare policy, social work practice, social work education

INTRODUCTION

At-risk drinking in the United States is a prevalent problem associated with many individual and societal costs. However, most individuals do not seek the necessary care to reduce or eliminate use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Therefore, it is critical actions that need to be taken to address this serious public health need. The purpose of this article is to present a review of the pertinent literature regarding at-risk alcohol use in the United States and discuss how social workers are among the public health service professionals that have the opportunity to play an important role for establishing brief intervention services on a national level.

EPIDEMIOLOGY OF AT-RISK DRINKING

At-risk drinking comprises risk-level use (i.e., drinking five or more drinks on one occasion for men and four or more drinks on one occasion for women; Dawson, Grant, & Ting-Kai, 2005), binge drinking (i.e., consuming five or more drinks on one occasion in the past month; National Survey on Drug Use and Health, 2009), heavy drinking (i.e., consuming six or more drinks within approximately 1 to 2 hours in the last 30 days; Madras et al., 2009), and alcohol abuse and dependence (i.e., criteria as defined in the Diagnostic and Statistical Manual of Mental Disorders,
Alcohol is the most commonly used drug in the United States, and consequences of at-risk use persist as major short-term and long-term threats to individual and community health (SAMHSA, 2010; U.S. Department of Health and Human Services, 2000). Alcohol-related deaths are the third leading cause of preventable death for Americans (Mokdad, Marks, Stroup, & Gerberding, 2004). Nearly 80,000 alcohol-attributable deaths per year accounted for 2.3 million years of potential life lost between the years of 2000 to 2005 (Center for Disease Control and Prevention [CDC], 2008, 2009). The annual financial burden that society bears attributed to risk level drinking is estimated to be $223.5 billion, or $746 per person in the United States (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). The economic cost of at-risk drinking exceeds that of asthma, diabetes, and high blood pressure combined (Ensuring Solutions to Alcohol Problems, n.d.). More than 60 individual medical conditions have been related to at-risk drinking (Room, Babor, & Rehm, 2005), which include chronic gastrointestinal, cardiovascular, and mental health disorders as well as several types of terminal cancers (Homann, 2005; Lieber, 1995; Rosen, Miller, & Simon, 2008). One half of those who suffer from alcoholism have been documented to experience mild to severe brain damage (Berman & Marinkovic, 2003).

Risk-level alcohol consumption is consistently implicated as a major risk factor for nearly all categories of unintentional (falls, crashes, burns) and intentional (homicide, suicide, assaults, child maltreatment; Blondell, Looney, Krieg, & Spain, 2002; Bureau of Justice Statistics, 2010; Lowenstein, Weissberg, & Terry, 1990) fatal and nonfatal injuries (CDC, 2004; Freedland, McMicken, & D’Onofrio, 1993; U.S. Department of Health and Human Services, 2000). In 2001, emergency departments provided care for 314,304 alcohol-related unintentional traumatic injuries (Shults, Elder, Hungerford, Strife, & Ryan, 2009). In all trauma centers, approximately 10% of patients have confirmed tests showing alcohol intoxication at the time of admission (National Trauma Data Bank, 2011). However, rates of alcohol intoxication among Level-1 trauma center (most acute care) patients have been documented to be as high as 50% (Gentilello et al., 1999). Furthermore, in studies of a number of types of medical settings (ranging from primary care to trauma), Madras et al. (2009) reported rates for heavy alcohol use ranged from 42.1% to 55.6% among patients who were screened. Those who are intoxicated are 1.5 to 2 times more likely (than those who were not intoxicated) to be readmitted for another injury within a very short period of time (1–3 years; Cherpitel, 1993, 1994; Treno, Gruenewald, & Ponicki, 1997; Watt, Purdie, Roche, & McClure, 2004).

**Alcohol-Related Health Disparities**

Patterns of at-risk drinking and the related consequences are often disproportionately higher among particular racial and ethnic minority groups in the United States. The highest overall rates of alcohol dependence and alcohol abuse are among American Indians or Alaska Natives (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2006). However, in looking at particular subgroups of ethnic minorities, Hispanic males who are less acculturated in the United States report higher rates of alcohol abuse and dependence than all other groups (Caetano, Ramisett-Mikler, Wallisch, McGrath, & Spence, 2008). Binge drinking rates are also highest among Hispanics compared to all other races and/or ethnicities (National Survey on Drug Use and Health, 2009). Furthermore, although non-Hispanic Whites are more likely to develop alcohol dependence in their lifetime than other races and/or ethnicities, Hispanic and Black Americans are more likely than Whites to have recurrent or persistent dependence (Chartier & Caetano, 2010). Hispanic and Black drinkers are also more likely than Whites to report negative social consequences resulting from drinking (Mulia, Ye, Greenfield, & Zemore, 2009). Altogether, at-risk drinking presents a major public health problem for minority groups as well as society at large.
Unmet Alcohol Treatment Needs and Screening and Brief Intervention

In light of these levels of at-risk drinking among individuals in the United States and the subsequent biological and injury-related consequences, it is important that concerted actions be taken to intervene and prevent at-risk drinking. Approximately 19 million individuals in 2008 were estimated to be in need of alcohol treatment in the United States, with roughly 8% of those individuals actually seeking alcohol treatment (SAMHSA, 2009). As a result of this unmet treatment need and the serious health repercussions of at-risk drinking, a number of settings outside of traditional substance abuse treatment facilities have been identified as possibly effective locations to deliver low-cost brief alcohol interventions. These settings include mental health clinics (Spear et al., 2009), criminal justice settings (Lapham, 2004; Watt, Shepherd, & Newcombe, 2008), and health care settings (Beich, Thorsen, & Rollnick, 2003; Nilsen et al., 2008). Although some of these non-substance-abuse treatment settings have received attention in the research literature, health care settings, in particular, have been identified as key locations in which those who drink at risk levels can be identified, receive alcohol interventions, and potentially be referred to other treatment settings for more specialized care. Screening and brief intervention (SBI) was conceptualized, developed, and tested starting more than 35 years ago (Chick, Lloyd, & Crombie, 1985; Kristenson, Ohlin, Hulten-Nosslin, Trell, & Hood, 1983) to help individuals seeking medical care and who drink at risk levels to decrease use and avoid related risk behaviors. Systematic alcohol screening and providing brief interventions to those who are positive for at-risk drinking have shown positive results across health care settings for a number of health behavior improvements, including alcohol use (Madras et al., 2009).

SBI IN HEALTH CARE SETTINGS

Screening injured patients for at-risk drinking generally falls into two categories: (a) biological screening and (b) self-report screening. Biological instruments include blood alcohol concentration analyses that test the alcohol content present in one’s blood (MedlinePlus, 2009). Self-report instruments are established using psychometric methods and ask patients about drinking patterns and behaviors indicative of levels of at-risk drinking. Some well-known instruments include the Michigan Alcohol Screening Test (MAST; Selzer, 1971), the CAGE (Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers; Mayfield, McLeod, & Hall, 1974), and the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monterio, 2001). Each of these measures can be administered in fewer than 10 minutes (NIAAA, 2003). Briefer instruments, known as “single-item screeners,” are also commonly used to detect risk use patterns (Seale et al., 2006; Smith, Schmidt, Allensworth-Davies, & Saitz, 2009). If single-item screeners are positive, it is recommended to follow up with multi-item measures to avoid false-positive results (NIAAA, 2007).

Patients identified as at-risk drinkers are eligible for a brief intervention. Brief interventions in health care settings can best be described as falling along a continuum of types of interventions, ranging from prescriptive to those based in motivational interviewing (MI; Cochran & Thompson, 2012). On the prescriptive end, interventions are more directive and less patient centered, focusing on prescribing what patients should do to improve alcohol use (NIAAA, 2007). In contrast, interventions based on MI are more guiding than directive and are aimed at eliciting from patients the need for change (Rollnick, Miller, & Butler, 2008). Practice behaviors illustrative of MI-based brief interventions include open-ended questions, examination of ambivalence, and exploration of pros and cons of change (Longabaugh et al., 2001; Miller, Zweben, DiClemente, & Rychtarik, 1995). MI has a well-established history as a treatment modality for encouraging health behavior change, particularly with alcohol and drug abuse (Lundahl & Burke, 2009; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).
Primary Care

SBI has been tested and proven to be efficacious in a number of health care settings. One of the first locations in which SBI was tested was primary care settings. Brief intervention studies in primary health care settings have shown reductions in a number of alcohol use behaviors. For instance, SBI in primary care settings have demonstrated reductions in alcohol use (Cowperthwaite & Burnett, 2011; Fleming, Brown, & Brown, 2004; Fleming & Manwell, 1999; Manwell, Fleming, Mundt, Stauffacher, & Barry, 2000), risk-level and heavy drinking episodes (Curry, Ludman, Grothaus, Donovan, & Kim, 2003; Fleming, Manwell, Barry, Adams, & Stauffacher, 1999; Manwell et al., 2000), and severity of alcohol-use-related problems (Lock et al., 2006), including hospital care related to alcohol consumption (Fleming, Barry, Manwell, & Johnson, 1997).

Outcomes for brief intervention delivered in primary care settings have showed not only clinical efficacy, but cost savings benefits. Fleming et al. (2000) demonstrated a savings of $56,000 in health care costs for every $10,000 spent on SBI services one year after brief intervention delivery. Furthermore, Fleming et al. (2002) showed drinking reductions among intervention recipients were consistent over a 4-year period, producing an approximate savings of $43,000 for every $10,000 spent in health care costs.

Internal Medicine and Clinics

Brief alcohol interventions delivered in internal medicine departments and health care clinics were also among the first health care settings where SBI trials were undertaken. Studies in these settings have likewise demonstrated SBI efficacy for helping at-risk drinkers. Outcomes have shown that brief interventions delivered to patients in internal medicine departments and clinics have reduced levels of alcohol consumption (Chick et al., 1985; Holloway et al., 2007; Yun-Fang, Mei-Chu, Yea-Pyng, & Ching-Yen, 2009), symptoms of alcohol dependence (Yun-Fang, et al., 2009), and levels of alcohol-related problems (Chick et al., 1985), including sick days from work, hospital stays, and mortality rates (Kristenson, Trell, & Hood, 1981).

Effectiveness of brief interventions among subgroups of internal medicine patients has also been examined. In particular, for patients who report alcohol use at unhealthy levels (but who are not alcohol dependent), the receipt of SBI has demonstrated reduced drinking and improved health outcomes (Saitz et al., 2009). Likewise, female intervention recipients have also been noted to have improved treatment seeking outcomes compared to men following SBI (Saitz et al., 2009).

Emergency Departments

Emergency departments (EDs) have also been settings in which the efficacy of brief alcohol interventions has been tested. SBI trials in EDs have demonstrated reductions in alcohol use (Monti et al., 1999; Neumann et al., 2006) and alcohol use severity (Bazargan-Hejazi et al., 2005; Haque et al., 2003). Other outcomes for SBI in this service area have shown reductions in alcohol-related problems, including drinking and driving (Monti et al., 1999) and future injuries (Longabaugh et al., 2001; Monti et al., 1999). Brief alcohol interventions delivered in emergency settings have also shown increased alcohol treatment seeking from patients (Neumann et al., 2006) and compliance with and completion of alcohol treatment (Runge, Garrison, Hall, Waller, & Shen, 2002).

Subgroup analyses have also demonstrated the effectiveness of SBI for populations seeking emergency care. For instance, one secondary analysis showed reductions in injury recidivism for ED patients who received SBI following a motor vehicle crash compared to other patients (Mello et al., 2005). Other analyses of SBI moderators in emergency settings identified causal attribution (the association between alcohol use and the injury) as a factor associated with lowered drinking outcomes for intervention recipients (Barnett et al., 2010; Walton et al., 2008). That is to say,
patients who connect their alcohol use and their injury have demonstrated improved drinking outcomes following receipt of a brief intervention compared to those who do not make a similar connection between their drinking and injury.

Trauma Centers

Trauma centers are also health care settings in which brief interventions for at-risk drinking have been tested. The first of these studies was carried out by Gentilello et al. (1999). The results of this study showed significant reductions in alcohol use among patients with low to moderate drinking levels. In a 3-year follow up, this study demonstrated a nearly 50% reduction in subsequent injuries requiring hospital admission. A similarly positive research study that provided SBI to trauma patients showed that recipients of a brief intervention were less likely to be arrested for driving under the influence of alcohol in the 3 years following the intervention (Schermer, Moyers, Miller, & Bloomfield, 2006). Furthermore, the results of this study noted that for every nine brief interventions delivered, one driving under the influence (DUI) was prevented.

Subgroups of trauma center patients have responded particularly well to brief interventions. For instance, patients with traumatic injuries diagnosed as alcohol dependent have demonstrated greater reductions in alcohol use than those with lower levels of drinking (Field & Caetano, 2010a). In terms of ethnic differences among trauma patients who drink at risk levels, Hispanic SBI recipients have reported greater reductions in alcohol use than their counterparts (Field, Caetano, Harris, Frankowski, & Roudsari, 2010). In a similar vein, Hispanic patients who were matched to Hispanic clinicians providing brief interventions also have reported better drinking outcomes than their counterparts after discharge (Field & Caetano, 2010b).

SBI delivered in trauma centers has also demonstrated financial benefits for the health care system. Cost-benefit analyses have demonstrated a savings of $3.81 for every $1 spent on SBI services. As a result, if all eligible patients in Level-1 trauma centers throughout the United States received a brief alcohol intervention, this would result in a total savings of $1.82 million each year in health care costs (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005).

CURRENT NATIONAL SUPPORT AND BARRIERS TO SBI

As a result of the empirical evidence for brief intervention delivery in health care settings for at-risk drinking, SBI has been endorsed on a national level for service delivery. For primary care settings, the U.S. Preventive Services Task Force (USPSTF; 2004) recommends SBI service delivery to all eligible adults and pregnant women. In addition to primary care, the American College of Surgeons (ACS; 2006) also endorses the delivery of SBI in trauma centers. Specifically, the College requires that all Level-1 and -2 trauma centers screen for at-risk drinking and that Level-1 centers provide brief alcohol interventions to patients who screen positive (ACS, 2006). In addition to established support for SBI, the Joint Commission (a chief accreditation body for health care organizations in the United States) is currently developing performance measures related to screening, brief intervention, and referral to treatment (Joint Commission, 2012), which measures have the potential to play an important role in encouraging the delivery of SBI in health care settings.

Billing and Reimbursement

Adding to these supports for SBI delivery, in 2007, a coalition consisting of the Physician Leadership on National Drug Policy, Ensuring Solutions (a policy think tank based at George Washington
University), the Office of National Drug Control Policy, and the Center for Substance Treatment (a program of the Substance Abuse and Mental Health Services Administration) successfully influenced the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) to make SBI a billable service code for reimbursement for public and private health insurance plans (Alcoholism & Drug Abuse Weekly [ADAW], 2007b). In addition to creating the codes on paper, CMS allotted the necessary budgetary resources for Medicare codes and Medicaid codes (ADAW, 2007a). The average Medicaid screening reimbursement cost reported by CMS is around $21, and the average reimbursement cost for a 15- to 30-minute intervention counseling session is around $62 (U.S. Department of Health and Human Services, 2008). These financial means allow for reimbursement of SBI for persons assessed to have substance use issues and that would benefit from a short intervention session with their medical or mental health provider. The national level endorsement for SBI by the USPSTF and the ACS, the AMA/CMS billing codes, and the federal funds for reimbursement have been a positive step for universal implementation of SBI within the nation’s health care system.

It is unfortunate, though, that since the billing codes for SBI were made official in 2007 (U.S. Department of Health and Human Services, 2008), few states have taken the necessary legislative steps to make reimbursement from CMS possible. The 10 states that have taken the steps to turn on their reimbursement codes to make billing possible are Iowa, Maryland, Minnesota, Montana, Oklahoma, Oregon, Tennessee, Virginia, and Washington. Wisconsin has been reported to have turned on its codes for the reimbursement of some SBI services for pregnant women (American Public Health Association, 2008; Behavioral Healthcare, 2008; Emergency Medicine News, 2009). The problem of turning on SBI billing codes for states has been based in the fact that state legislatures must pass amendments (i.e., expansions) to their Medicaid programs that include funds to draw down federal matching funds (Fornili & Alemi, 2007). Such a Medicaid expansion is particularly prohibitive in the current economically strained environments existing in states.

Parity, Health Care Reform, and SBI

In spite of these challenges for reimbursement from the time billing codes were established, recent federal legislation stands to help expand the reach of SBI nationally. The Mental Health Parity Legislation that was signed into law in 2008 along with the Affordable Care Act that was signed into law in 2010 have the potential to have a major impact on SBI in the United States (Barry & Huskamp, 2011). The primary purpose of Mental Health Parity was to ensure that mental health services and substance abuse treatment benefits within health insurance policies were equal to medical and surgical benefits (Barry & Huskamp, 2011; Buck, 2011). The Affordable Care Act works in concert with Mental Health Parity to provide a large stream of funding (i.e., through publicly funded health insurance plans) for individuals to receive mental health and substance abuse services (Barry & Huskamp, 2011). A major focus of these two laws and the anticipated funding will be to provide substance abuse services within primary care settings and medical homes (Buck, 2011).

Screening patients for alcohol abuse issues, delivering brief interventions, and referring patients to more intensive alcohol treatment programs (as circumstances call for with patients) are core substance abuse services that will be delivered in primary care settings and medical homes for health insurance policy holders under the Affordable Care Act (HealthCare.gov, 2011; National Association of State Alcohol and Drug Abuse Directors, 2011; National Prevention Council, 2011). The focus of the Affordable Care Act on medical homes and primary health care providers delivering brief intervention is grounded in the advantage possessed in these settings for coordination of care and continuity of services with patients (Buck, 2011). For instance, providers in these settings should have longer term relationships with patients to build rapport and track
progress. This continuity of care will be further enhanced as a result of the major emphasis of health information technology, particularly electronic medical records, in the Affordable Care Act (Barry & Huskamp, 2011; Buck, 2011). With these strengthened record-keeping capabilities, not only will providers be able to more accurately track the behavioral health history of patients, but also the referral to treatment aspect of brief intervention can possibly be enhanced to ensure follow through with referrals and specialized treatment services.

**Uniform Accident and Sickness Policy Provision Law**

Notwithstanding the positive prospects for SBI based on the Mental Health Parity legislation and the Affordable Care Act, these federal laws will have little influence over established state statutes regarding possible denials of coverage for those who are injured while intoxicated. The Uniform Accident and Sickness Policy Provision Law (UPPL) was created as a model statute in 1947 by the National Association of Insurance Commissioners and was implemented in most states (Gentilello et al., 2005). The purpose of the UPPL is to allow insurers the ability to not reimburse health insurance claims made by individuals who have suffered injuries related to alcohol or drug intoxication. Although this law has been repealed in many states, it nevertheless remains in the health insurance codes of 26 states (Cochran, 2010).

This law could have serious repercussions for health care providers and injured patients. For instance, fear of the UPPL can be a disincentive for health care providers to identify if patients are intoxicated in fear of not being reimbursed, subsequently leaving patients with the entire burden of their medical bills (Cochran, 2010; Gentilello, Donato, et al., 2005). With the average costs of injury care for those who are alcohol positive being more than $10,000 (O’Keeffe, Shafı, Sperry, & Gentilello, 2009), such an economic burden could lead to possible financial ruin for individuals (Cochran, 2010). In addition to economic repercussions of the UPPL, not screening patients for alcohol or drugs would have harmful medical ramifications as a result of the possible interactions between narcotics or alcohol and the medications administered as part of medical care (Brown, 1987; Vagts, Iber, & Noldge-Schomburg, 2003). Furthermore, if patients, specifically drunk drivers, are not screened for alcohol after being brought to emergency or trauma centers after car crashes, they may go undetected and unpunished for breaking drinking and driving laws (Gentilello, Donato, et al., 2005).

Some insurers claim that the UPPL is antiquated and is not used to deny payment for health care costs for patients’ injuries related to drugs or alcohol (Texas House of Representatives, 2007). National surveys of trauma surgeons (Gentilello, Donato, et al., 2005) and social workers practicing in health care settings (Cochran & Davis, 2012) report, however, to have observed denials of reimbursement. Therefore, with the existence of the UPPL and the above discussed shortcomings for reimbursement, SBI in some settings face potential challenges. Yet, looking beyond these possible challenges towards SBI’s proven efficacy and the currently existing support, it is apparent SBI is well situated to continue playing an important role for substance abuse services in the United States’ health care system.

**SBI, SOCIAL WORK, AND FUTURE OPPORTUNITIES**

Given the strengths, challenges, and future prospects for SBI, social workers have an important opportunity to help move this evidence-based practice forward. Social workers are among the health care professionals identified as critical in the delivery of SBI services. For instance, the ACS (n.d.) includes social workers as one of the specific health care disciplines to which SBI responsibilities in trauma centers may be assigned. Further, social workers have been successfully
utilized in a number of research trials as the interventionists to deliver SBI services (Blow et al., 2006; Dauer, Rubio, Coris, & Josep Marti, 2006; Schermer et al., 2006). Analyses have also shown that social workers are among the nonphysician health care providers that can deliver a similarly efficacious intervention as those provided by physicians (Murray, 2010). Therefore, social workers are well positioned for taking advantage of opportunities that exist for SBI in the substance abuse services field.

SBI and Social Work Practice and Education

Social workers have the opportunity to help lead in the establishment of SBI under health care reform and maintain SBI’s continued presence within other health care settings (i.e., Level-1 trauma centers). Greater involvement in the SBI field for the profession is a natural fit given the connection between SBI, social work practice, and social work education. In terms of practice, brief interventions are regularly applied in a number of health care settings in which social workers are employed and have interactions with patients who misuse substances (Kotrla, 2005). For instance, emergency and trauma departments are locations in which patients who have experienced serious injury receive medical treatment, and social workers regularly provide mental and behavioral health services to patients in these settings (Auerbach & Mason, 2010). Not only do social workers have the opportunity to build on the existing history of SBI delivery in these settings (ACS, n.d.; Murray, 2010), but also, this model of social workers delivering substance abuse services in emergency and trauma settings could be easily translated into primary care and medical home health care environments.

In addition to practice applications, social workers must further recognize the importance of substance abuse screening and intervention for social work education and training. Brief intervention education for social work students has been the topic of discussion within the context of helping social workers become more involved with the SBI service (Kotrla, 2005). However, in spite of the fact that a conceptual practice model has been developed regarding SBI delivery for social workers (Bliss & Pecukonis, 2009) and the SBI education/training modalities have been developed for health care professionals (including social workers; Baez, 2005), social work’s interdisciplinary and intradisciplinary addictions education require improvement (Haack & Adger, 2002). Baez (2005), for instance, utilized the Objective Structured Clinical Examination (OSCE) with medical, nursing, and social work students to teach brief intervention skills. Not only did outcomes demonstrate a significant increase in knowledge and competencies relevant to SBI, but more importantly, these investigators identified the important fact that substance abuse services in health care settings happen within a practice environment populated by a variety of disciplines. No one health care profession possesses an exhaustive knowledge with respect to substance abuse and how it affects the individual patient. It is therefore beneficial for providers to receive training and work collaboratively to address substance abuse through multidisciplinary teams in health care settings—drawing on multiple perspectives to serve patients’ needs. Social workers would excel as leaders of such multidisciplinary teams that aim to account for multiple perspectives for SBI service delivery as a result of their training in group facilitation (Council on Social Work Education [CSWE], 2010) and strengths-based perspective.

SBI as a Means to Improve Health Equity

Opportunities for social workers and SBI do not exclusively exist within practical and educational settings. Social workers possess a core charge to provide services to individuals in need, particularly those who are underserved or marginalized (National Association of Social Workers [NASW], 2008). As was mentioned above, SBI has been supported for use in various health care
settings. Therefore, brief intervention provides an access point and opportunity for social workers to screen patients, deliver interventions, and provide referrals to a large number of individuals who otherwise would not have the opportunity to receive substance abuse services in other settings. For instance, recent in our work (Field, Cochran, & Caetano, 2013) regarding ethnic differences in the response of patients to brief alcohol interventions, we noted that Hispanic patients ($n = 139, 30.7\%$) were more than 3 times as likely than non-Hispanic White patients ($n = 76, 12.4\%$; $\chi^2 = 53.5, df = 1$, odds ratio $= 3.12$, 95$\%$ confidence interval 2.28, 4.26) to be alcohol dependent and not have sought treatment prior to being recruited for the SBI study. Moreover, racial/ethnic minorities have been observed to receive substance abuse treatment at lower levels than their White counterparts (Schmidt, Ye, Greenfield, & Bond, 2007) and are less likely than Whites to become involved in no-cost mutual-help groups, such as Alcoholics Anonymous (Arroyo, Westerberg, & Tonigan, 1998; Schmidt, Greenfield, & Mulia, 2006).

SBI delivery in health care settings can occur with all patients seeking medical services. Therefore, SBI delivered in health care settings opens a subsequent door to help identify and provide interventions and referrals to patients from these groups who may not have access to alcohol abuse services some other way. Hispanic patients, in particular, have been noted to suffer high levels of at-risk alcohol use, alcohol-related consequences, and challenges for receiving alcohol treatment (Caetano et al., 2008; Mulia et al., 2009; Zemore, Mulia, Yu, Borges, & Greenfield, 2009). Individuals who are Hispanic have been observed to respond better to SBI compared to their other groups of individuals with respect to alcohol reductions (Field & Caetano, 2010b; Field, Caetano, Harris, Frankowski, & Roudsari, 2010). Therefore, SBI delivered to Hispanic patients has the ability to address an important behavioral health issue for this population. To take advantage of SBI’s opportunities for practice, education, and health equity, social workers and other health care professionals must take concerted future steps in the areas research, policy, education, and practice.

RECOMMENDATIONS

Research

There are many important questions in the SBI field that must be answered by health care professionals, including social workers, as SBI continues to move forward in the United States. One of the most important questions is to examine the implementation of SBI for alcohol in health care settings. The majority of research conducted to date has been randomized clinical trials that have emphasized internal validity to demonstrate the efficacy of the intervention for targeted behavior improvement (Field, Baird, Saitz, Caetano, & Monti, 2010). Efficacy trials are those experiments that adhere closely to methodologies that will insure internal validity (Rubin & Babbie, 2008). Effectiveness trials, on the other hand, are those experiments that employ research strategies aimed at testing interventions or independent variables in more real-world settings and circumstances (Rubin & Babbie, 2008). An ideal trajectory for the development of behavioral research begins with efficacy RCTs, which subsequently evolve into effectiveness trials (Carroll & Rounsaville, 2003; Field, Baird, Saitz, Caetano, & Monti, 2010; Westfall, Mold, & Fagnan, 2007). Therefore, effectiveness trials could help to provide necessary information that will help SBI make a successful transition into a nationally funded service in health care settings.

In addition to the need for effectiveness trials, it will also be beneficial for the field to further explore the effectiveness of SBI among subgroups. As was cited above, there have been a number of moderator analyses that have helped draw out subpopulations that are responsive to brief interventions. One of these groups, in particular, was Hispanic patients in trauma settings (Field & Caetano, 2010b; Field, Caetano, et al., 2010). Field and Caetano postulated a number of
hypotheses as to why Hispanic patients demonstrated a better response to SBI compared to other
groups (Field & Caetano, 2010b; Field et al., 2013), which included cultural scripts that could
have enhanced the impact of the intervention (Field & Caetano, 2010b). It would be valuable to
design and conduct studies that examine such hypotheses. If the findings of such studies were
supported, they could help SBI service delivery planning and execution for Hispanic patients and
give insights into the important role of culture in brief intervention delivery.

In addition to subgroup response to SBI, an emerging area for brief intervention is drug
abuse. Some studies have demonstrated promising preliminary findings for brief interventions
reducing illicit (Bernstein et al., 2005; Madras et al., 2009) and prescription drug abuse (Zahradnik
et al., 2009). Further, other studies are currently underway and will provide added information to
the field regarding SBI for drugs (NIDA: 5R01DA026088-05, C. Field, M. Velasquez; NIDA:
5R01DA025068-05, R. Saitz; NIDA: 5R01DA026014-05; P. Roy-Byrne; 5R01DA025991-05,
NIDA: G. D’Onofrio). Given social workers’ frequent interactions and experience in working
with patient populations that abuse illicit and prescription drugs, it will be important that social
work research lead in designing and disseminating future SBI studies that not only target alcohol
but also the spectrum of substances of abuse.

A final potential area of research would be to build on the above-mentioned study that
identified social workers as being able to deliver as effective of brief interventions as other
health care professionals. In particular, this continued research should not take the form of which
profession “does it the best,” but rather, future studies should examine what shared attributes
among health care professions help increase the impact of SBI for patients who drink at risk
levels. Examining therapeutic mechanisms of change within the addiction treatment literature
has been an informative line of inquiry providing insight into how and why individuals reduce
substance misuse (Longabaugh & Magill, 2011). Research in this area for SBI could aid clinicians
to understand what aspects of SBI are in fact stimulating change and which aspects are not helpful.

Policy

As social workers successfully fulfill leadership positions within health care organizations as
experts in training and delivery of brief interventions, they will be able to take a greater leadership
role in the development, implementation, and refinement of SBI policy in the United States. For
instance, though trauma departments and primary care have been included as health care settings
where brief intervention will continue or begin to occur, other medical settings do not currently
require alcohol screening and intervention, such as internal medicine, emergency medicine, and
obstetrics departments, to name a few. One area social workers might excel within this context
of SBI policy is through the coalition building to extend required service delivery to additional
health care settings. An important tool in efforts to build public policy is the work that can be
accomplished through coalitions that specialize and target particular issues (Hansen-Turton, Ritter,
& Valdez, 2009; Holyoke, 2009). Such a team approach to SBI policy would allow social work to
move forward an important evidence-based practice and guide a vital initiative for health equity.

In connection with social workers partnering and organizing to facilitate SBI implementation,
social workers also should work to collaborate with surgeons to repeal the UPPL (Cochran, 2010).
As was mentioned above, the UPPL is a statute in one half of states in the country that permits
insurance companies to deny reimbursement for injury care to those whose injuries are related to
substance intoxication. The UPPL will likely be unaffected by health care reform and will remain
in operation in those states where repeal has not been successful or has not been attempted. With
an alliance between social workers and surgeons, social workers (as a financially disinterested
party) could help represent the severe impact the UPPL could have on middle- and low-income
patient populations (Cochran, 2010; Cochran, Montgomery, & Bell, 2012).
Education and Practice

To move social workers to the front line of health care providers in the United States being trained and delivering brief interventions, the CSWE should include SBI among its individual-level practice behaviors for accreditation. Practice behaviors are specific skills and knowledge social work students must be taught and subsequently retain to successfully complete courses in accredited social work programs (CSWE, 2010). These behaviors must be measurable in nature to certify students’ mastery of the skill. Including SBI into social work accreditation standards would not only aid social work students to learn a marketable, billable, and relevant skill for professional practice, but would also help distinguish social work education within the professional health and behavioral health sciences.

A possibly ideal approach for jumpstarting SBI among the CSWE competencies could be through a partnership between a school of social work and a medical school residency training program that is either funded (SAMHSA, 2011) or simply committed to providing education and training to residents on SBI. Knowledge sharing between medical and social work (a) educators and (b) students could yield a rich learning environment for all involved and potentially produce better trained professionals in field. Possessing this level of expertise and credentialing for social workers would have the potential to place them in leadership roles within practice settings to subsequently provide training and supervision for other health care professionals with respect to SBI service delivery.

CONCLUSION

At-risk drinking is associated with a number of societal problems and individual health consequences. Most individuals who are in need of help for alcohol use disorders do not receive treatment. Screening patients for at-risk drinking and delivering brief interventions is an evidence-based practice for reducing alcohol use and alcohol-related risk behaviors. SBI has been demonstrated to be efficacious in a number of health care settings, and some policy-level supports, including billing codes for public/private insurance along with reimbursement funds from the federal government, have been designed to facilitate its delivery.

Some challenges, however, impede SBI delivery generally, not the least of which are problems for reimbursing SBI and the potential denial of payment for care of those who are intoxicated at the time of their injury. In spite of these challenges, health care reform sets the stage for a large expansion of SBI to all individuals in the United States. Social workers have the opportunity to play an important role in helping establish SBI nationally, but they must become more involved in its delivery and educating new social workers with respect to SBI practice. Future research opportunities also exist with respect to SBI. As social workers take leadership roles in SBI practice, education, and answering research questions through empirical evaluation, SBI will continue to make important advancements in addressing and improving the serious public health burden of at-risk drinking.

REFERENCES

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