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Screening and Brief Intervention Practice Model for Social Workers in Non-Substance-Abuse Practice Settings

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The social costs of substance abuse problems in the United States are staggering. Although social work has a long history of working in the substance abuse field, the profession does not pay similar attention to potential substance abuse problems in non-substance-abuse practice areas despite the high prevalence of substance abuse in these settings. A screening and brief intervention practice model that emphasizes a feasible and practical framework for social workers to screen for potential substance abuse problems in non-substance-abuse practice settings and make appropriate brief interventions is provided. Implications for social work educators, administrators, and practitioners are discussed.

KEYWORDS *brief intervention, practice model, screening, social work, substance abuse*

Despite efforts to prevent substance abuse problems in the United States, a sizable portion of the population aged 12 years and older continues to use illicit and legal substances. Results from the most recent National Survey on Drug Use and Health (NSDU; Substance Abuse and Mental Health Services Administration [SAMHSA], 2006) indicated that in 2005 slightly more than 8% of the population aged 12 years or older were current users of illicit drugs. The rates of current alcohol use ranged from slightly more than 4% for

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persons aged 12 or 13, increasing to slightly more than 67% for persons aged 21 to 65, and then dropping to 40% for persons aged 65 years and older. An estimated 6.6% of the population aged 12 and older engaged in heavy drinking. Slightly more than 29% of the population aged 12 and older were current users of tobacco.

The impact of substance abuse is enormous in terms of how it affects individuals, families, and communities. According to the National Institute on Alcohol Abuse and Alcoholism [NIAAA] (2000), the 1998 estimated social cost of alcohol disorders was \$185 billion. More than 100,000 persons die each year from alcohol-related causes such as cirrhosis of the liver, cerebrovascular disease, hemorrhagic stroke, coronary heart disease, hypertensive disease, and cancer (Rehm, Gmel, Sempos, & Trevisan, 2003). The negative impact of drug abuse is similar, as the 2002 societal cost of drug abuse was \$180.8 billion (Office of National Drug Control Policy, 2004). Similar to alcohol abuse, drug abuse is responsible for a host of health and mental health problems. Yet, of all the psychoactive substances, tobacco use causes more illness and death, as more than 440,000 persons in the United States die each year from cigarette smoking (Centers for Disease Control and Prevention, 2002). On the whole, substance abuse costs the United States more than \$484 billion per year (National Institute on Drug Abuse [NIDA], 2007a).

Social work has a long history of working with persons with substance abuse problems (Straussner, 2001). Whereas the early focus of practitioners typically involved the provision of treatment services, the profession has since expanded its involvement to also include involvement in research, administration, policymaking, and program development domains. This involvement, though, may be provided by only a small percentage of all social workers, as data from the third survey of the NASW Practice Research Network (PRN; Smith, 2005) revealed that only 16% of social workers reported being involved in addictions work, with only 3% stating that addictions were their primary practice areas. Although the PRN study indicated that social workers do work with clients with substance abuse issues in a variety of organizational and practice settings, there is a question as to whether social workers are adequately trained to address substance abuse: Although more than 75% received some substance-abuse-specific training in their lifetimes, only 3.8% did so in the past 12 months.

Social workers have acknowledged this deficiency as a majority of respondents in the PRN study reported that more training related to substance abuse is needed (Smith, 2005). Similarly, in a study of the training needs of a sample of 303 social workers who worked in randomly selected substance abuse treatment programs in New England, Hall, Amodeo, Shaffer, and Vander Bilt (2000) found that limited previous training experiences, barriers to accessing current training, and lack of clinical supervision impacted the training needs of respondents at the same time that slightly more

than 70% of respondents indicated having some need for substance abuse training.

Potentially even more troubling is the concern that social work education and practice does not pay similar attention to substance abuse issues in non-substance-abuse practice areas despite the fact that “substance use problems permeate the social systems and client populations that social workers serve” (National Association for Children of Alcoholics [NACOA], 2006, p. 6). In non-substance-abuse practice areas such as child welfare, family services, employee assistance, schools, and geriatrics, where substance abuse problems are prevalent, social workers are often the first service providers to work with persons who might have substance abuse problems, yet the workers often have received little or no training in the delivery of substance abuse services (Hall et al., 2000). In a study of the development of a measure of potential barriers that social workers might experience in discussing substance abuse with their clients, Hohman, Clapp, and Carrillo (2006) identified three factors—attitudes, worker–client relationship skills, and knowledge—that can affect how social workers work with clients who might have substance abuse problems.

The growing recognition of these deficiencies led to efforts beginning in the late 1990s to increase social workers’ knowledge and skills in dealing with substance abuse problems (NACOA, 2006). For example, the National Association of Social Work (NASW) began to offer a specialty practice section on Alcohol, Tobacco and Other Drugs in 1996. The NASW also offers a certification for social workers who specialize in the substance abuse field. *The Journal of Social Work Practice in the Addictions*, a peer-reviewed journal, was introduced in 2001. The Association for Medical Education and Research in Substance Abuse (AMERSA) developed a strategic plan for interdisciplinary faculty development that includes a set of core competencies. Social work is one of the 14 health care disciplines that is included. Finally, the NIAAA has an online curriculum on the prevention and treatment of alcohol use disorders that was designed especially for social workers (see www.nacoa.org).

Despite these initiatives, there is a question as to whether the social work profession needs to be more proactive in responding to the potential for substance abuse problems in non-substance-abuse practice settings. For example, the Institute of Medicine (as cited in Donovan, 1999) has suggested that screening for potential substance abuse problems be expanded to also include areas where the probability of problems with alcohol and other drugs is high—most, if not all of which, are common areas of social work practice.

The purpose of this article is to present a screening and brief intervention practical model social workers can use for addressing potential substance abuse problems in non-substance-abuse practice settings. In light of some of the barriers that social workers face in attempting to address substance

abuse issues in diverse practice areas (see Hall et al., 2000; Hohman et al., 2006), the model is designed to be practical and feasible to use.

SCREENING AND BRIEF INTERVENTION PRACTICE MODEL

The Screening and Brief Intervention Practice (SBIP) model is designed to allow social workers in non-substance-abuse practice settings to seamlessly incorporate screening questions on potential substance abuse in their normal assessment protocols followed by a brief intervention that is linked to the screening results. The four integrated components of the model are illustrated in Figure 1.

Underpinning Assumptions

The model rests on a foundation of underpinning assumptions that not only support the other components of the model, but are also responsible for maintaining the integrity of the model as a whole:

1. Substance abuse problems, whether addictive in nature or not, are implicated in every social work practice area. Alcohol and other drug abuse can either cause or exacerbate problems in these areas such as increasing the potential for neglecting children in child welfare settings, or destabilizing persons with psychiatric problems in mental health settings. Left unrecognized and untreated, substance abuse problems can impede and potentially block desired treatment outcomes.

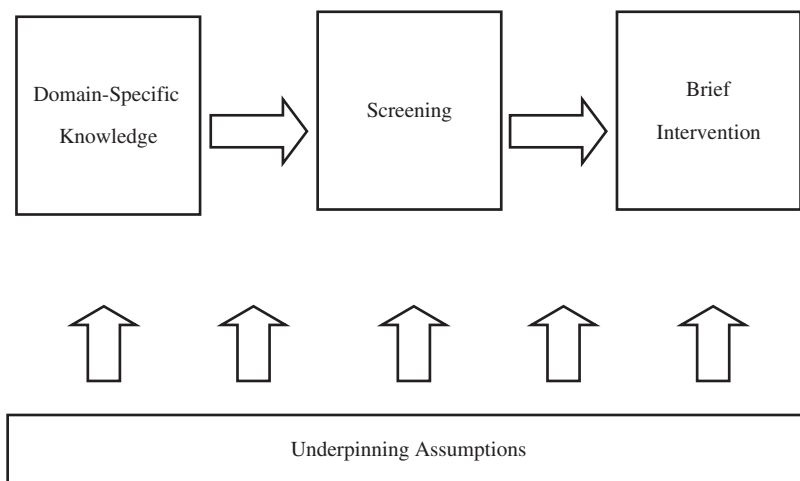


FIGURE 1 Screening and brief intervention practice model.

2. Social workers are often unprepared in their education to adequately understand, screen for, and intervene in substance abuse issues in non-substance-abuse practice areas. Any attempt to engage in screening and brief intervention will be ineffective if social workers do not have adequate content knowledge of substance abuse in their practice domains.
3. Screening and brief intervention protocols not only can be relatively easily and seamlessly added to existing biopsychosocial assessment protocols, they can be more effective than formalized substance abuse questions on assessment forms that might encourage dishonest answers from clients on their use of alcohol or other drugs. In contrast, a relaxed, nonconfrontational tone that is more conversational in nature can elicit more honest answers from clients about possible substance abuse problems.
4. Client functioning in non-substance-abuse practice domains can be improved when potential substance abuse problems are adequately addressed by social workers who engage in screening and brief intervention. This improvement has positive implications for all of the client's social networks including families, friends, and coworkers.
5. A client-centered screening and brief intervention protocol that is practical and feasible in nature, although not ideal for all practice scenarios, is better than no protocol at all.

Domain-Specific Knowledge

Social work educators continue to debate whether education regarding substance abuse should be required as a separate course of study or whether such content should be infused in all practice courses. Although resolution of this debate does not appear to be likely anytime soon, there does appear to be some consensus that social work practitioners should have a basic understanding of how substance abuse problems can be implicated in all practice settings. This domain-specific knowledge can provide a context for understanding how potential substance abuse problems affect client functioning, the impact that substance abuse problems can have on treatment outcomes, and the importance of social workers utilizing screening and brief intervention protocols to address potential substance abuse problems.

Following is an overview of some of the common non-substance-abuse practice settings where social workers have a prominent focus, the prevalence and implications of substance abuse problems in these areas, and Web-based resources where social workers can easily find additional information on substance abuse issues.

Child Welfare

Studies indicate that substance abuse problems are implicated in between one third and two thirds of all families who are referred to child welfare

services (Semidei, Radel, & Nolan, 2001). In a 1998 Government Accounting Office (GAO) study on child protection systems in Los Angeles, California, and Cook County, Illinois, substance abuse was a problem in more than 70% of active foster care cases (Ryan, Marsh, Testa, & Louderman, 2006). Research indicates that children of substance-abusing parents are more likely to experience abuse (physical, sexual, or emotional) or neglect than children in non-substance-abusing households (Child Welfare Information Gateway, 2003; Walsh, MacMillan, & Jamieson, 2003).

The National Center on Substance Abuse and Child Welfare (NCSACW) (<http://www.ncsacw.samhsa.gov>) was created by the U.S. Department of Health and Human Services and is funded jointly by the SAMHSA Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth, and Families, Children's Bureau's Office on Child Abuse and Neglect. Among the helpful resources available on the NCSACW Web site are a variety of downloadable products including screening and assessment information, online tutorials and training, Microsoft PowerPoint presentations that include plenary sessions and workshops, information on conferences, and related links.

SAMHSA has developed a new guidebook for families in the child welfare system that are affected by substance use disorders. The Screening and Assessment for Family Engagement, Retention, and Recovery is available for download at no cost at <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17633>.

Mental Health

Research has shown a strong relationship between substance abuse issues and mental health problems. According to the National Comorbidity Survey, the lifetime prevalence rate for alcohol, drug, and mental health disorders is 48% (Rosenthal & Westreich, 1999). According to the National Institute of Mental Health (2004), more than 90% of people who died by suicide, the 11th leading cause of death in the United States in 2004, had the risk factors of depression and other mental health disorders or a substance abuse disorder (often in combination with other mental health disorders). Poor treatment outcomes have been associated with the comorbid relationship between mental health disorders and substance abuse due to numerous factors, including a lack of clarity in diagnostic classification and insufficient communications between substance abuse and mental health staffs (Orlin, O'Neill, & Davis, 2004).

The National Institute of Mental Health (<http://www.nimh.nih.gov/>) provides a host of resources on mental health issues, including booklets, easy-to-read publications, pamphlets, fact sheets, and summaries. Many of these resources note the implication of substance abuse problems in causing, exacerbating, and treating mental health issues. In addition, information about

mental health programs, mental health topics including the role of substance abuse, publications, and additional resources, are provided by SAMHSA's National Mental Health Information Center (<http://mentalhealth.samhsa.gov>).

Aging

Although the use of alcohol and other intoxicants generally declines with age, substance abuse among the elderly is a growing public health concern (Gambert & Albrecht, 2005). There is also concern that people aged 80 years and older, who are the fastest growing segment of the elderly population, might have additional risks, although there is little information available on this population (Watts, 2007). Prevalence estimates of alcoholism in elderly that live in the community are between 3% and 15%, and as high as 18% to 44% for elderly in general medical and psychiatric inpatient settings (Gambert & Albrecht, 2005). Gambert and Albrecht also cite a 1998 report by the CSAT that stated that "drug abuse affects up to 17% of adults older than age 60 years and constitutes an invisible epidemic" (p. 1038).

The Geriatric Social Work Initiative (GSWI; <http://www.gswi.org/index.html>), which is sponsored by the John A. Hartford Foundation, collaborates with social work programs, organizations, and other funders to prepare social workers for working with older adults and their families. The GSWI Web site contains information on GSWI programs, current issues in aging, educational resources, and career resources. SAMHSA (http://www.samhsa.gov/Matrix/matrix_older.aspx) also provides a host of resources on substance abuse issues with older adults, including professional resources, Web resources, technical assistance, publications, programs and activities, and conferences.

Health Care

Substance abuse is implicated in numerous medical problems, including hepatitis, sexually transmitted diseases, skin and soft-tissue infections, infective endocarditis, tuberculosis, pneumonia, neurological complications, and cardiovascular complications (Gourevitch & Arnsten, 2005). Yet, the role of substance abuse issues can be hidden, depending on the level of honesty of patients and the adequacy of assessment by clinicians. In addition, although the negative health consequences of substance abuse can occur at high doses of the substance or after prolonged use, some of these consequences can occur after just one use of the substance (NIDA, 2007b). The NIAAA (<http://www.niaaa.nih.gov>) and the NIDA (<http://www.nida.nih.gov>) offer numerous resources on substance abuse and health. For example, *Alcohol Research & Health*, NIAAA's quarterly, peer-reviewed scientific journal, is available online at the NIAAA Web site. NIDA has a Web site (<http://www.nida.nih.gov/medstaff.html>) for physicians and other health professionals.

Other Practice Areas

Although this discussion centered on some of the most common non-substance-abuse practice settings in which social workers practice, they are not the only settings. Domestic violence, schools, criminal justice, adolescents, and maternal and child health are other common social work practice areas where substance abuse problems are prevalent. Although exploring domain-specific knowledge in all of the possible practice areas is beyond the scope of this article, content information and other resources that social workers will find helpful are available through some of the Web sites discussed earlier, including sites of the NIDA (<http://www.nida.nih.gov>), the NIAAA (<http://www.niaaa.nih.gov>), and the SAMHSA (<http://www.samhsa.gov>).

SCREENING

The combination of the prevalence of substance abuse problems in the non-substance-abuse practice settings where social workers commonly practice and the inadequate training and supervision these workers receive about substance abuse (Hall et al., 2000), calls on the profession to take a much more proactive role in responding to substance abuse problems in their practice settings. The essential question is what such a response should entail.

Difference Between Screening and Assessment

One area to begin in examining this question is by helping social workers understand how to identify clients who might have a substance abuse problem. Screening, which is one of the initial functions of assessment, helps to identify clients who might have a substance abuse problem or who might be at risk for developing one (Donovan, 1999). Unlike a more comprehensive assessment or diagnosis, screening is not designed to establish the nature and extent of substance abuse problems (Connors & Volk, 2003). Although screening is typically brief and inexpensive in nature, one concern that social workers need to be aware of is “the probability of incorrectly identifying someone as having a problem when he or she does not (a false positive) or as not having a problem when in fact he or she does (a false negative)” (Donovan, 1999, p. 188). Although screening measures can vary greatly in their accuracy, Connors and Volk (2003) provided a description of dimensions that can be used in evaluating the strengths of particular measures, including their sensitivity, specificity, predictive value, likelihood ratios, and receiver operating curves, with the “gold standard” generally being a full diagnostic evaluation.

One pragmatic dimension that Connors and Volk (2003) did not discuss concerns the feasibility of using the measure given the training, time, and

administrative constraints that social workers might experience. Although a particular screening measure might achieve gold standard status, it will likely not be used if it is too confusing, cumbersome, or time-consuming for social workers to incorporate into their assessment protocols. This is especially true in practice settings where there is no administrative policy supporting the inclusion of substance abuse screening protocols in the biopsychosocial assessment process. Thus, “keep it simple” appears to be a philosophy worth following if social workers are to begin to screen for possible substance abuse problems in their practice settings, especially when they have not done so before.

Another consideration involves understanding the link among screening, assessment, and treatment. Although providing an in-depth assessment of the potential for substance abuse problems in every client a social worker sees in non-substance-abuse practice settings is both impractical and costly, there are clinical populations that warrant a comprehensive assessment along with a brief intervention to address their substance abuse problem. The utility of using a screening approach is that it allows the social worker to determine who requires an in-depth assessment and possible referral to substance abuse treatment and who does not. Connors and Volk (2003) highlighted the interrelationships among screening, assessment, and treatment by noting that “screening ideally should occur in a manner that facilitates subsequent assessment or referral for assessment among persons identified as positive on the screening measure” (p. 22).

Considerations in Selecting Screening Measures

Substance abuse screening is typically employed through either structured interviews or paper-and-pencil measures. An overview of some of the most frequently used screening measures is discussed next. These measures tend to be specific in terms of whether they focus on alcohol or other drugs, and are validated with particular populations or groups with specific characteristics. Thus, it is important for social workers to select their screening measures carefully, as one screening instrument might not necessarily fit all populations.

Overview of Substance Abuse Screening Measures

Choosing among the wide variety of screening measures that are available can be a daunting task for social workers as the “screening measures have considerable variability in length and potential applicability to particular screening contexts” (Connors & Volk, 2003, p. 26). Fortunately, two evidence-based resources are available to assist social workers with this task. First, the NIAAA (Allen & Wilson, 2003) developed a guide for clinicians and researchers in assessing alcohol problems. In addition to providing detailed information on screening measures, the guide contains information on

diagnosis, assessment, treatment planning, and outcome evaluation. Second, the new SAMHSA screening initiative Web site focuses on Screening, Brief Intervention, Referral, and Treatment (SBIRT; <http://www.sbirt.samhsa.gov/>). SBIRT is a “comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders” (SAMHSA, 2007).

The use of standardized screening instruments is becoming more popular among clinicians (Straussner, 2004). Among the more frequently used measures that social workers might consider in screening their clients are the Michigan Alcoholism Screening Test (MAST; Selzer, 1971); the Drug Abuse Screening Test (DAST; Skinner, 1982); the CRAFFT (Knight et al., 1999) used for adolescents; the TWEAK (Russell, 1994), developed to screen for at-risk drinking during pregnancy; the AUDIT (Babor, de la Fuente, Saunders, & Grant, 1992); and the MAST–G (Blow et al., 1992), a geriatric version of the MAST.

For social workers who wish to incorporate the SBIP model in their work, but who are not sure where to start in selecting a screening measure, the CAGE (Ewing, 1984), a very brief and nonconfrontational tool for detecting alcoholism in adults and adolescents over 16 years of age (Allen & Wilson, 2003), is recommended for several reasons. First, the name of the measure is an acronym for the four questions the measure contains, making it relatively easy to remember and seamlessly add these questions into the normal biopsychosocial assessment process social workers engage in with new clients. Second, the CAGE is available in the public domain. Third, the scoring for the CAGE is easy to interpret, eliminating the need for social workers to conduct more comprehensive diagnostic assessments to determine whether a potential problem exists. Fourth, the ease in scoring can simplify the decision-making process on which brief intervention to use.

Following are the CAGE questions and the scoring criteria:

- C** Have you felt you ought to *CUT* down on your drinking?
- A** Have people *ANNOYED* you by criticizing your drinking?
- G** Have you felt bad or *GUILTY* about your drinking?
- E** Have you ever had a drink first thing in the morning (*EYE-OPENER*) to steady your nerves, get rid of a hangover, or get the day started?

Each item answered in the affirmative is scored as 1 point. A score may range from 0 to 4. A score of 1 is considered a positive screen and requires a more in-depth assessment of the client’s alcohol use.

Whereas the CAGE (Ewing, 1984) is designed to screen for alcoholism, the CAGE–AID (Brown & Rounds, 1995) consists of the same four questions that are adapted to include other drugs by asking about both drinking and drug use in each question. Scoring for the CAGE–AID is the same as for the CAGE.

Guidelines for Conducting Screenings Using the CAGE

Unless substance abuse screening is already a part of the assessment protocol, social workers might want to “keep it simple” as they learn how to incorporate screening in the assessment process. Perhaps the easiest way to do this involves using a short screening measure such as the CAGE, the acronym of which facilitates remembering the focus of each question (i.e., cut down, annoyed, guilty, eye-opener). This allows the social worker to incorporate screening questions seamlessly when talking with clients about how they manage stress or whether they have health concerns. For example, after asking a client how she manages the stressors in her life that led her to see the social worker, the social worker could then ask if the client drinks alcohol. If the client responds in the affirmative, the social worker could insert one of the CAGE questions, such as “Have you ever felt you should cut down on your drinking?,” into the conversation. As the conversation unfolds, the social worker can insert other CAGE questions.

An important aspect of this more conversational style of screening is that it occurs during a part of the assessment process when asking questions about drinking would seem to be reasonable in the client’s eyes. This helps to minimize any defensiveness on the part of the client and can lead to more honest answers. It is essential to note that the social worker is not trying to diagnose whether the client is an alcoholic or drug addict, nor is the social worker attempting to break through client denial about potential substance abuse problems. All the social worker is doing during the screening process is exploring in a natural and nonconfrontational manner whether the client might have a problem with alcohol or other drugs.

Social workers should also remember that it is much less threatening to first ask questions about drinking rather than illicit drug use, as more people drink (Straussner, 2004). However, this recommendation should not be construed as meaning the social worker should not ask the client about drug use as well, given the prevalence of concomitant alcohol and drug use in our society today.

Interpreting Screening Results

Screening measures can vary in terms of their scoring criteria. For example, one affirmative response using the four-question CAGE (Ewing, 1984) indicates a positive screen and the need for more in-depth assessment, whereas the 10-question AUDIT (Babor et al., 1992) assigns various point levels depending on the frequency of use with a total score of 8 or more indicating at-risk drinking and the need for further assessment. In contrast, two affirmative responses using the six-question CRAFFT (Knight et al., 1999) indicates a positive screen and the need for further assessment.

One way social workers can clinically interpret screening results is to categorize a client's substance use and place it along a continuum of risk (Institute of Medicine, 1990). This continuum includes the following:

- *Abstinence*: A person within this category does not use a substance and thus is not at risk of developing a substance abuse problem.
- *Low-risk, nonproblematic use*: Within this category, any substance use is not associated with negative biological, psychological, or social consequences.
- *High-risk, nonproblematic use*: Within this category, the frequency and quantity of substance use places the person at high risk for negative biopsychosocial consequences. Here the individual has continued to climb the ladder of risk, increasing the likelihood of negative outcomes. However, no problematic consequences have yet occurred.
- *Substance abuse*: Within this category, the person's substance use is now associated with negative biopsychosocial consequences.
- *Substance dependence*: Persons within this category account for approximately 5% of the total population and are considered addicted. They continue to use substances despite the negative consequences associated with this use. The primary symptoms of addiction include loss of control over use, obsession with obtaining and using the substance, compulsive use of the substance when it is available, increased tolerance in that more and more of the substance is needed to obtain the desired effect, and physical dependence.

BRIEF INTERVENTION

The growing recognition that problems associated with alcohol and other drug use beginning at lower levels of consumption than would warrant a diagnosis of substance use disorders and the need for treatment has helped support the increased use of brief intervention as a form of secondary prevention (Moyer & Finney, 2005). Two key aspects of these interventions are that they are typically delivered by professionals who do not specialize in addiction treatment and are targeted toward people who are not necessarily addicted. As such, the goal of the intervention is to encourage people to alter their substance use without creating resistance, although these interventions can sometimes be used to motivate someone who has more serious substance abuse or dependence problems to seek treatment (Moyer & Finney, 2005).

Although clinical trials in primary care settings in numerous countries have supported the efficacy of brief interventions in helping people with alcohol problems ("Brief Treatment for Problem Drinkers," 2004; O'Connor, 2005) and other substance use problems such as tobacco and drugs ("Treatment Approach," 2004), significant situational and attitudinal barriers prevent

many practitioners from utilizing these strategies with their patients, including “negative attitudes toward substance users, fear of losing patients, feeling it is not part of their work, and a sense that nothing they do can help persons with substance problems” (“Treatment Approach,” 2004, p. 6). In addition, “studies have also found that many physicians feel a lack of confidence, skills and abilities to intervene in substance abuse problems, largely due to a lack of training opportunities at medical schools” (“Treatment Approach,” 2004, p. 7). Although similar studies have not been conducted with social workers, it is likely they experience similar barriers, especially due to limited training and supervision opportunities they receive in addressing substance abuse issues (Hall et al., 2000; Hohman et al., 2006).

In response to these barriers, the NIAAA (2005a) released a new research-based guide to help physicians screen and intervene for alcohol problems in their patients. Available at no charge at the NIAAA Web site (www.niaaa.nih.gov), this updated guide provides a clinical approach to screening and brief intervention for alcohol use, clinician support materials, patient education materials, online materials for clinicians and patients, and additional resources. Despite being developed for physicians, the guide can be utilized by social work practitioners and administrators, although the comprehensive nature of the guide and the wealth of material it contains might make it difficult to know where to begin for some social workers. In this light, a set of guidelines for a feasible brief intervention protocol that social workers can follow is presented next.

Brief Intervention Guidelines

Scoring instructions for various screening instruments commonly call for further assessment when there are positive screening results, but less clear is what this means in terms of what the social worker should specifically do. Given that screening results can range along a hierarchy of no substance abuse problem to substance dependence, social workers who, due to the same lack of training and supervision that serve as barriers to engaging in screening for substance abuse, might not know how to respond in a manner that matches the degree of the substance abuse problem. For example, this can be important, as an elderly adult who drinks recreationally, yet whose drinking interferes with health problems such as hypertension, might have different needs than an adolescent whose occasional use of marijuana is causing school problems. In both cases the person is not addicted, but there is clear indication that their substance use is problematic to at least some degree, and could have even more negative implications over the long term if left unaddressed. The challenge in these cases, then, is to provide social workers with a client-centered brief intervention protocol they can follow.

One set of guidelines is the American Society of Addiction Medicine’s (ASAM, 2007) patient placement criteria for matching persons with addictive

disorders to appropriate levels of care based on an assessment of six dimensions including acute intoxication and withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use, or continued problem potential; and recovery environment. Mee-Lee (cited in Polcin, 2000) provided another perspective on using ASAM criteria that involves the clinician assessing each of the six dimensions and referring the client to the mix of services needed rather than focusing on the levels of care. In both of these applications of the ASAM criteria, the level of intervention is linked to the degree or severity of patient functioning.

Social workers can utilize a similar hierarchical arrangement to assist them in providing a brief intervention that matches the level of potential substance abuse problem. Social workers can categorize this potential along a 3-point continuum ranging from *no substance abuse problem* to *possible substance abuse problem* to *likely substance abuse problem*. Regardless of what level the client is on, the social worker should respond with an appropriate brief intervention that addresses the degree of the problem.

The following is an overview of a practical, simple-to-use, three-level brief intervention framework social workers can use in responding to all screening results. Screening results using the CAGE will be used as an exemplar.

- *No substance abuse problem*: In this level of the hierarchy, the CAGE score would be 0—indicating the client does not have a problem with alcohol or other drugs. The brief intervention could entail positively reinforcing the client's decision-making process relative to substance use. For example, a client who decided to abstain from alcohol use due to a high prevalence of familial alcoholism should be affirmed for this choice. Similarly, a client who decided to quit smoking cigarettes when she got pregnant can be affirmed for deciding to remain smoke-free. The power of positively reinforcing these kinds of healthy behaviors should not be minimized, as they can become the basis for helping clients improve their functioning in other biopsychosocial domains.
- *Possible substance abuse problem*: The CAGE score would be at least 1 to reach this level of brief intervention. When the results of a screen indicate there is a potential for having a problem with alcohol or other drugs that requires further assessment, the social worker can provide the client additional information such as brochures and fact sheets that have been downloaded from the NIDA, NIAAA, or SAMHSA Web sites. This nonconfrontational brief intervention is primarily informational in nature and designed to help increase client self-appraisal rather than making a definitive diagnosis. Moyer and Finney (2005) discussed how the use of technology such as computer programs can help to mitigate the time demands that can prevent practitioners from providing brief interventions. Another

option, especially when the likelihood of a substance abuse problem is higher or when a client admits to having a substance abuse problem short of being addicted, is for the social worker to recommend the client attend a self- or mutual-help group such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Moderation Management, Women for Sobriety, or Overcomers Outreach.

- *Likely substance abuse problem:* The CAGE score would be at least 2 to reach this level of brief intervention. Although the line between a possible substance abuse problem and a likely substance abuse problem can be blurred at times, there are occasions when the results of screening indicate a client requires a more comprehensive brief intervention. In these cases, social workers need to respond with a stronger brief intervention that links a client with an existing substance abuse treatment program in the community. This takes the need for conducting more comprehensive assessments out of the hands of social workers who might not have the training to engage in this level of diagnosis, and places the responsibility with clinicians (who might also be social workers) who have the necessary expertise. As compared to the second level of brief intervention, this level, given the increased risk of a substance abuse problem, moves beyond an informational focus the client can engage in alone to one that has the client engaging in a comprehensive assessment with a trained professional. Not only does this level of intervention provide additional feedback to the client about the existence of a substance abuse problem, but it facilitates the client receiving needed substance abuse treatment if the situation warrants.

There is a trade-off in using this simple guide for brief intervention, as it relies more on clinical judgment rather than an objective score on a screening instrument to determine what the level of brief intervention should be. In cases where the social worker is unsure what level the client is on, a conservative approach would be to default to a higher level of brief intervention. This clinical flexibility can be important as negative responses to screening questions such as the CAGE do not necessarily indicate the client does not have a problem with alcohol (“Brief Treatment for Problem Drinkers,” 2004).

DISCUSSION

Federal initiatives, such as the NIAAA’s (2005a) clinician’s guide on screening and intervening with patients who drink too much, SAMHSA’s (2007) SBIRT screening initiative, and the NIAAA’s (Allen & Wilson, 2003) guide for clinicians and researchers in assessing alcohol problems, represent the growing awareness of the need for increased screening and brief intervention strategies

in all practice settings where substance abuse problems might exist. Although these strategies have begun to be increasingly embraced by doctors and nurses in primary care settings (Edwards, 2004; Moyer & Finney, 2005; "Treatment Approach," 2004), the same is not necessarily true of social workers. Given the important role that social workers play in many of the non-substance-abuse practice settings in which substance abuse is prevalent, and the profession's long history of providing clinical services to persons in substance abuse practice settings, this omission needs to be addressed. O'Connor (2005) highlighted the importance of this by stating "ignoring problem drinkers is bad medicine" (p. 69). A similar statement can be directed to social work educators, administrators, and practitioners.

Although the profession has made strides in the past several years to correct this omission (NACOA, 2006), there is a question as to whether social work educators need to do more to provide social work students with the knowledge and skills they need to address substance abuse issues in diverse practice settings, especially those settings that are not specific to substance abuse. For example, the Social Work Curriculum on Alcohol Use Disorders (NIAAA, 2005b) provides lecture-ready modules developed by experts in alcoholism and social work research on numerous domains including (a) screening for alcohol problems in social work settings, (b) diagnosis and assessment of alcohol use disorders, and (c) motivation and treatment interventions. Given how easily this curriculum content can be added to clinical, policy, and program administration courses to help enhance student understanding of substance abuse problems, the difficulty in finding the curriculum on the NIAAA Web site, without knowing exactly where to look, can be a systemic barrier to social work educators who might want to include the content in their courses, if they only knew where to find it. In addition, there does not appear to be any data on how, or to what degree, the curriculum is being utilized by social work educators who are aware of the material and have accessed it. The net result is that a valuable and needed resource is underused—contributing to the problem of social work students not receiving enough education about substance abuse.

Social work administrators contribute to this omission when they fail to advocate for the inclusion of screening and brief intervention protocols in non-substance-abuse practice settings. In addition, this is compounded by the failure to provide adequate training and supervision for frontline social workers who would be in the best position to engage in screening efforts (Hall et al., 2000). Although these systemic barriers are not exclusive to social work settings, as general practitioners also experience them ("Treatment Approach," 2004), they can be considered part of a larger societal mindset that tends to turn a blind eye to substance abuse problems. Unfortunately, this tendency to engage in denial has staggering implications for the well-being of individuals, families, communities, and society as a whole in terms of the social costs of unrecognized and untreated substance abuse problems.

CONCLUSION

Although the SBIP model can be criticized for being too simple, as it recommends the use of the CAGE, a four-question screening tool, and a three-level hierarchy of brief interventions, at the expense of more comprehensive screening, assessment, and intervention strategies, the model does not preclude the utilization of more comprehensive screening and brief intervention strategies. Instead, the model is designed to be a practical and feasible starting point for social workers who might have little or no training, but who recognize the need to screen for substance abuse problems in the clients they serve and then provide brief interventions to prevent problems from becoming even larger. Given the prevalence of substance abuse problems in all social work practice areas, a default position of not screening for possible substance abuse problems or failing to provide brief interventions when substance abuse is indicated is not consistent with the mission of social work to help at-risk and vulnerable populations. The SBIP model addresses this inconsistency by providing social work educators, administrators, and practitioners a tool they can use in addressing substance abuse problems in all social work practice settings.

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