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Practice Perspectives

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Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Risky Alcohol and Other Substance Use: Best Practices for the Prevention and Treatment of Substance-Exposed Pregnancy in Girls and Women of Reproductive Age

More than half of children in the U.S. are exposed to alcohol before they're born, according to a recent study.[1] Unintended exposures, from alcohol use prior to pregnancy recognition, represented 80 percent of alcohol-exposed pregnancies (AEPs). Moreover, although the U.S. Surgeon General, Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists, along with other medical professional organizations, advise pregnant and lactating women to abstain from any substance use, nearly 1 in 7 pregnant women report drinking alcohol, and about 1 in 20 report binge drinking in the past 30 days.[2] In addition, 40 percent of pregnant women who drink also use other substances, most frequently tobacco and cannabis.[3]

Substance use during pregnancy poses serious health risks, including fetal alcohol spectrum disorders (FASDs), a range of lifelong disabilities that can occur with prenatal alcohol exposure.[4] Tobacco use during pregnancy increases risks of preterm birth, low birth weight, birth defects of the mouth and lip, and sudden infant death syndrome (SIDS).[5] Due in part to legalization, cannabis use is increasing nationwide. At the same time, a growing body of evidence shows that prenatal cannabis exposure is associated with neonatal intensive care unit admission, lower birth rates, preterm birth and higher stillbirth rates.[6] Studies also suggest that prenatal cannabis use may increase the chance of a child developing problems with attention, memory, problem-solving, and behavior later in life.[7] In addition, opioid use in pregnancy has been linked to preterm birth, stillbirth, and neonatal opioid withdrawal syndrome.

As the nation's largest occupation specializing in behavioral health — and a key workforce in preventing and addressing substance use disorders — social workers play a vital role in screening for prenatal substance use, performing evidence-based interventions to reduce substance-exposed pregnancy (SEP), and making referrals or delivering treatment for substance use. Social workers are also crucial to reinforcing the message that there is no known safe amount, no safe time, and no safe type of substance to take during pregnancy.

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The National Association of Social Workers (NASW), along with other leading healthcare workforce organizations, are members of the FASD National Partner Network, a cross-discipline initiative of the Centers for Disease Control and Prevention (CDC). In partnership with the Health Behavior Research and Training Institute at The University of Texas at Austin School of Social Work, NASW is working with the Network to prevent prenatal substance use by improving practice, education, and awareness among healthcare professionals.

This article adapts a recent literature review of alcohol screening, brief intervention, and referral to treatment (SBIRT) for girls ages 12 and older and women of reproductive age published in Alcohol Research: Current Reviews.[8] This resource has also been updated to address other substances, including cannabis and tobacco. Through this overview of screening instruments, brief interventions, and implementation issues, social workers can determine best practices for preventing and treating alcohol and other substance use during pregnancy.

SBIRT

The U.S. Preventive Services Task Force (USPSTF) recommends that social workers and other care providers screen all adults ages 18 and older, including pregnant women, for risky substance use and provide brief counseling interventions, when appropriate. SBIRT is meant to identify, reduce, and prevent problem drinking and other drug use and consists of three key components: screening, brief intervention, and referral to treatment. The first step is to administer a validated prescreen instrument as part of the routine intake procedure, to identify clients who are using substances at or above risky levels. If prescreen instruments suggest risky substance use, a more detailed assessment can be conducted to determine the level of use and inform brief intervention (BI) and/or treatment options. BIs are often based on motivational interviewing (MI) and foster awareness of alcohol- and other substance-related risks and consequences as well as motivation for change. If a client is identified to be using at levels suggesting a substance use disorder (SUD), then referral for specialized treatment for further assessment and care is recommended.

Screening

SBIRT starts with universal screening to identify clients who have, or are at risk for, alcohol- and other substance-related problems. Universal screening that meets SBIRT standards involves using a validated prescreen instrument limited to a few questions that need only brief responses. Prescreens and screens should work in succession, and because many instruments can serve both purposes, this process is sometimes simplified into a single step within clinical practice settings.

Universal prescreening and screening must be conducted with valid, age-appropriate instruments with cutoff scores based on sex and age. The following screening practices and instruments have been validated for use within specified age groups of girls and women. Table 1 provides additional information for each instrument mentioned.

Adolescents

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), Substance Abuse and Mental Health Services Administration (SAMHSA), and American Academy of Pediatrics (AAP) recommend that all adolescents and young adults ages 12 to 21 be screened for risky alcohol and other substance use behaviors on a yearly basis and as needed, during acute care visits.

Three prescreen options are applicable to adolescents: the two age-specific questions in NIAAA's Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide; the first three questions of the Screening and Brief Intervention (S2BI); and the three-item Alcohol Use Disorders Identification Test—Concise (AUDIT-C).

Screening instruments that have been validated for use with adolescents and can be used to inform next steps include the 10-item Alcohol Use Disorders Identification Test (AUDIT); Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD); and the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screening instrument.

Screening adolescents for risky substance use can be incorporated into psychosocial approaches. For instance, two conversation guides designed for use with adolescents in healthcare settings are the Home Environment, Education and Employment, Eating, Peer-Related activities, Drugs, Sexuality, Suicide/Depression, and Safety from Injury and Violence (HEEADSSS) tool, and the Strengths, School, Home, Activities, Drugs/Substance abuse, Emotions/Depression, Sexuality, Safety (SHADESS) tool.

Social workers should assure confidentiality to improve the accuracy of adolescent screening responses. In addition, federal and state privacy laws entitle adolescents to privacy regarding substance use treatments, so adolescents may benefit from a script ensuring that what is disclosed will not be shared with their caregiver unless an immediate risk of injury to oneself or another is divulged. Social workers should be aware of privacy laws and age requirements specific to the states where they practice.

Women of Reproductive Age

For women of reproductive age, the USPSTF recommends the use of brief prescreening instruments for alcohol with 1 to 3 items, such as the NIAAA-recommended Single Alcohol Screening Question (SASQ), to quickly identify those who may be at risk, including those who may be at risk of an SEP.

If a brief prescreening measure identifies someone at risk for alcohol misuse and/or SEP, a more comprehensive instrument should be used. For example, the 10-item AUDIT has been validated for use with women of reproductive age, and there are also several assessments designed specifically for this group, such as the Tolerance, Worried, Eye-Opener, Amnesia, K/Cut Down (TWEAK) screening instrument.

Screening Recommendations

Universal screening should start in early adolescence and be repeated regularly across settings that provide healthcare and social services to girls and women. However, screening instruments cannot replace a complete substance use assessment. Because these instruments are brief and, in many cases, can be self-administered, it is often recommended that they be used to inform additional steps based on the initial level of risk indicated by these screening instruments.

Settings with access to interdisciplinary professionals may find that more comprehensive assessments are practical, while settings with fewer resources may benefit from using brief instruments like the AUDIT, which has been validated for use across age groups. In addition, questions or measures may be added to assessment protocols to identify other factors correlated with female alcohol use behaviors, such as depression and anxiety, to better inform BI and referral practices. Moreover, social workers should remain sensitive to how they describe alcohol-related issues, as language such as "alcoholic" or "addict" is stigmatizing and may discourage clients from providing relevant information about their alcohol use.

Brief Interventions

BIs are evidence-based practices that are short, tailored conversations between clients and clinicians following screening results indicating risky alcohol use. The goal of BIs is to help those who are at risk of substance use-related consequences by explaining how their use may put them at risk and fostering their self-motivation for change. BIs often include conversations on standard drink sizes, low- versus high-risk drinking limits, and potential health and social consequences of drinking and other drug use. Another common component of BIs is providing personalized normative feedback, with research supporting the use of gender-specific feedback for women.

BIs for risky alcohol use are often based on the principles of MI, a collaborative, client-centered approach that can help women address their struggles with changing unhealthy behaviors. A core principle of MI is the use of non-confrontational methods to help clients guide themselves toward change without feeling the need to defend their choices.

Adolescents

The AAP recommends basing the intervention delivery for youth on the risk identified at the time of screening. Research suggests that encouragement from a provider may delay the start of alcohol use and thus promote adolescent brain maturation. These interventions may be especially important for female adolescents, especially girls at risk of early alcohol initiation, because of the damaging effects of alcohol on their brain development.

BIs are recommended when an adolescent screens positive for risky drinking. A recent meta-analysis of 185 studies showed BIs reduced drinking and alcohol-related consequences for adolescents and young adults, with effects lasting up to one year across demographic groups.

BIs using MI have been shown to be effective with substance-using adolescent populations. Much of the supporting evidence suggests that adolescents decrease their risky behavior gradually rather than moving directly to abstinence. There is also some

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research showing that BIs for alcohol use may be particularly effective for adolescent girls, especially when the provider is also female and the information is provided within an ongoing provider-patient relationship.

Women of Reproductive Age

Strong research supports the use of BIs among pregnant and nonpregnant women of reproductive age to reduce alcohol consumption and risks linked to SEPs. Several randomized controlled trials with pregnant women have found significant reductions in alcohol use and improved newborn outcomes following the use of BIs.

In addition to the previously mentioned components of BIs, interventions with women of reproductive age often also include feedback on the potential effects of substance use on fetal and child development. Experts recommend that postpartum women receive information on infant exposure to alcohol and other substances through breastmilk and that contraceptive use be integrated into BIs with nonpregnant women who are at risk of an SEP.

A highly effective prevention and intervention program developed for use with women of reproductive age is CHOICES, an established alcohol-exposed pregnancy (AEP) prevention program based on the principles of MI and designed to provide nonpregnant women of reproductive age with information to help them avoid an AEP. The CHOICES protocol has been widely disseminated across health and social service settings, including primary care facilities, jails, and sexually transmitted disease clinics.

Referral to Treatment

Referral to treatment is designed to help people in need of more intensive treatment with accessing appropriate treatment, choosing facilities, and overcoming barriers to treatment engagement. Treatment options for SUDs may include residential treatment and self-help or support group programs. There are also options that are exclusively for women, such as the Women for Sobriety program. Specialized alcohol treatment should take into account a woman's medical, social, economic, spiritual and cultural needs. Social workers should be aware of local treatment options in order to conduct warm handoffs—referrals facilitated in the presence of the client to encourage communication between the patient and treatment team—when needed. Special attention to the treatment selection for pregnant and postpartum women is needed to ensure appropriate medical care and social support options are available. Social workers may choose to access SAMHSA's online resource guide (FindTreatment.gov); NIAAA's Online Treatment Navigator tool (https://alcoholtreatment.niaaa.nih.gov); and NIAAA's publicly available resource guides, with information specific to referrals: Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide) and The Healthcare Professional's Core Resource on Alcohol, which offers complimentary continuing education credit for social workers (www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol).

Facilitating SBIRT Implementation

Studies show that some providers may feel uncomfortable implementing SBIRT. One study found that one-third of women who endorsed alcohol consumption were not asked how much they drank and that most women engaging in risky drinking did not receive advice about reducing their drinking.[9] Another study showed that about half of women at risk of an AEP did not receive information about this risk from their healthcare providers.[10]

Evidence suggests that having a practice champion, deploying an interprofessional team, communicating the details of each SBIRT step, establishing relationships with referral partners, conducting ongoing SBIRT training for sustainability, integrating SBIRT practices with the organization's workflow, and incorporating SBIRT into electronic health records promote ongoing SBIRT efforts. CDC's Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices is a resource that takes social workers through the process of adapting alcohol SBI to their specific practice (https://stacks.cdc.gov/view/cdc/26542).

Technology

The use of digital technology may help facilitate SBIRT in clinical settings that lack staff and time for ongoing face-to-face implementation. A recent systematic review of women's experiences with technology-based screening, such as completing an SBIRT session on a tablet, found that the perception of anonymity made it easier to share potentially stigmatizing information compared to in-person screening methods. Studies also suggest

that the flexibility offered by some technology-based treatments may also appeal to women who are not willing or able to participate in more formal treatment programs. Social workers should follow up with clients or patients who complete digital SBIRT screenings to ensure screenings have been completed correctly and provide intervention and referral to treatment as appropriate.

Conclusion

SBIRT is crucial to the ongoing identification of and intervention for substance use during pregnancy. By taking the lead in prevention and intervention efforts, social workers can help promote lifelong health and well-being among the clients they serve, including those at risk of an SEP.

Additional Resources

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TABLE 1. SCREENING INSTRUMENTS FOR ALCOHOL AND OTHER SUBSTANCES

INSTRUMENT	APPLICABLE AGE RANGE	SUBSTANCE TYPE	TIME	NOTES
NIAAA Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide	Adolescents ages 9 to 18	Alcohol	~2	• Asks about personal alcohol use as well as that of friends • Endorsed by the AAP and includes elementary, middle and high school-age appropriate questions
Screening to Brief Intervention (S2BI)	Adolescents ages 12 to 17	Alcohol, tobacco, cannabis, and other substances	~2	• Asks one frequency-of-use question per substance
Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)	Adolescents ages 12 to 17	Alcohol, tobacco, and cannabis	~2	• An adaptation of the questions found within NIAAA's guide
Alcohol Use Disorders Identification Test (AUDIT)	Adolescent girls ages 12 to 19, adults, pregnant women	Alcohol	~2 to 3	• The most widely tested alcohol screening instrument • Evidence suggests a lack of gender bias between female and male adolescents
Alcohol Use Disorders Identification Test-Concise (AUDIT-C)	Adolescent girls ages 12 to 19, adults, pregnant women	Alcohol	~1	• Identifies the quantity and frequency of alcohol consumption
Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)	Adolescents ages 12 to 21	Alcohol, cannabis, and other substances	~2 to 3	• Recommended by both NIAAA and AAP • Able to detect preconception substance use in small cohort of pregnant women ages 17 through 25
NIAAA Single Item Alcohol Screening Questionnaire (SASQ)	Adults	Alcohol	~1	• Also referred to as the "single binge drinking question"
Quick Drinking Screen (QDS)	Women of reproductive age	Alcohol	~1	• Data show that women's answers to QDS items were highly similar to 90-day timeline followback responses • Publicly available USPSTF Final Recommendation Statement that includes NIAAA SASQ question
Tolerance, Worried, Eye Opener, Amnesia, K-Cut Down (TWEAK)	Pregnant women	Alcohol	~2	• Validated questionnaire for identifying drinking among women, including those at risk for an AEP
Parents, Partner, Past, Present Pregnancy (4P's Plus)	Pregnant women	Alcohol, tobacco, cannabis, and other substances	~1	• Recommended by the USPSTF
Cannabis Use Disorder Identification Test – Revised (CUDIT-R)	Adults ages 18 and older	Cannabis	~2-4	• Assesses problematic use of cannabis
Drug Abuse Screening Test (DAST-10)	Adults ages 18 and older	Cannabis and other substances	~6	• Evaluates substance use and its consequences • Does not assess alcohol or tobacco use
National Institue on Drug Abuse (NIDA) Single-Question Screening Test	Adults ages 18 and older	Cannabis and other substances	~1	• Asks about use of illegal drugs or prescription medication for non-medical purposes. Can also be used for cannabis given that it is now legal in many states.

Social workers should be aware of local treatment options in order to conduct warm handoffs—referrals facilitated in the presence of the client to encourage communication between the patient and treatment team—when needed.

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FOOTNOTES

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