

Issue Brief: Translating Trauma-Informed Care into Practice

Trauma Screening, Brief Intervention and Referral to Treatment (T-SBIRT)

Trauma-Informed Care

It is estimated that over 70% of the population worldwide has experienced a traumatic event.¹ Based on rapidly expanding insights into the scope and consequences of trauma exposure, trauma-informed care has become an ascendant service framework. As evidence to this effect, the Substance Abuse and Mental Health Service Administration (SAMHSA) has articulated general guidelines² for implementing trauma-informed care across multiple service sectors such as:

- Physical, Mental and Behavioral Health
- Child Welfare
- Workforce Development
- Juvenile and Criminal Justice

Building on SAMHSA's guidance, practitioners and researchers have begun to translate the principles of trauma-informed care into trauma-informed practices.³ For instance, Berliner and Kolko (2016) write that trauma-informed care should incorporate the following strategies: "screening for trauma exposure, assessing trauma impact, and increasing access to trauma-specific treatment (p. 170)." Consistent with these recommendations, Dr. James Topitzes of the Institute for Child and Family Well-being developed a Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT) protocol that is designed to identify trauma exposure and symptoms among adults and refer them to trauma-focused treatment as needed.

T-SBIRT Overview

The original SBIRT model addresses alcohol and drug misuse through a brief, universal approach. Most commonly delivered within healthcare settings,

SBIRT has been shown to reduce drinking and drug use among risky substance users.^{4,5} It applies motivational interviewing principles to encourage behavior change and provides the conceptual foundation for T-SBIRT.

Like SBIRT, T-SBIRT draws on the public health ethic of delivering widespread and minimally burdensome screening and referral services to improve population health. It is client-centered and brief, requiring approximately ten minutes to complete. Due to its brevity and uncomplicated design, it can be readily integrated into various service settings such as primary and specialty healthcare centers, behavioral and mental health treatment clinics, child welfare and social service agencies, and criminal justice facilities. Professionals from case managers to clinicians can conduct T-SBIRT sessions with the proper training and technical assistance.

While the structure of T-SBIRT is similar to SBIRT, it has two distinct purposes: (1) to help clients generate insight into the extent and effects of their trauma exposure, and (2) to enhance their motivation to engage in behavioral or mental health services. The steps of T-SBIRT consist of the following motivational interviewing elements: seeking permission to share information, providing information and education, asking open-ended questions, reflecting and summarizing responses, and reinforcing statements reflecting motivation to change.

T-SBIRT Feasibility Study

A recent study demonstrated that it was feasible to implement T-SBIRT in primary care community clinics.⁶ Clinic administrators agreed to the study because they: a) recognized the corrosive influence of trauma on patient health and well-being, and b) were dedicated to offering inte-

T-SBIRT protocol

When delivering T-SBIRT, service providers complete the protocol with their clients in the following sequence:

1. **Make a brief statement** about known connections between stress, trauma and poor life outcomes.
2. **Ask permission** to screen for and discuss issues of stress and trauma.
3. **Ask about sources** of current life stressors using open-ended questions.
4. **Screen for exposure** to traumatic events using the Trauma History Screen⁷ or other validated tool.
5. **Assess for current symptoms** with the Primary Care Post-Traumatic Stress Disorder (PC-PTSD) screen.⁸
6. **Ask about** "positive" and "unhelpful" strategies used to cope with trauma memories and symptoms.
7. **Inform clients** that it can be difficult to eliminate substance misuse or other unhelpful coping strategies without simultaneously addressing trauma.
8. **Gauge and enhance motivation** to pursue behavioral or mental health services.
9. **Make a referral to treatment** when indicated following best referral practices.
10. **Offer an educational booklet** on post-traumatic stress, published by the federal government.⁹
11. **Implement an evidence-based** calming exercise if necessary.

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grated and trauma-informed healthcare services. The study gathered data on more than one hundred adults (N=112) that lived in central city neighborhoods and qualified for clinic services due to low-income status. Of the full sample of study participants, 53.7% were African American, 36.1% were Latino/a, and 5.6% were White. Participants' ages ranged from 18 to 74, with an average of 41.4 years, and just over 40% were female.

Prior to their primary care physician visit, study participants received SBIRT and T-SBIRT services from a mental or behavioral health specialist. Feasibility data emerged from integrity checklists that service providers completed during sessions and from treatment acceptability surveys that clients completed after sessions. Results showed that T-SBIRT is a highly promising approach according to five different indicators of feasibility:⁶

- a) **Suitability:** 96% of sample endorsed exposure to at least one lifetime traumatic event; 56% of sample generated a positive PC-PTSD screening result
- b) **Acceptability:** 3.00 or 'very acceptable' was the average overall patient rating of T-SBIRT
- c) **Compliance:** 100% of patients who were offered T-SBIRT accepted and completed services
- d) **Fidelity:** 97% of all T-SBIRT integrity checklist steps were completed by providers
- e) **Outcomes:** 63% of sample accepted a mental/behavioral health referral at session's end

Each of the results summarized above meets or exceeds published standards for feasibility.¹⁰ For instance, rates of model fidelity over 80% are considered to be

excellent. The study's observed rate of referral acceptance is also higher than acceptance rates of other brief health referral services.^{5,11} Based on these encouraging results, T-SBIRT is now being implemented and tested in additional community-based settings.

Future Directions

The Institute for Child and Family Well-being recently launched a new initiative with funding from the Wisconsin Partnership Program to implement T-SBIRT within workforce development programs. Research has shown that adults seeking job services face multiple barriers to employment due in part to their history of trauma exposure.¹² Addressing trauma with T-SBIRT while also promoting job placement may therefore improve program outcomes.

Additionally, the Institute has joined forces with the Central Racine County Health Department in Wisconsin to combine T-SBIRT with universal home visiting services. With funding from the Racine County government and the United Way of Racine County, the project aims to implement T-SBIRT with women once they return home from the hospital after giving birth. This approach has the potential to increase community-wide access to trauma-informed mental health services during a particularly sensitive period for mothers and their infants.

By introducing trauma-related screening and referral practices within universal home visiting services, T-SBIRT has the potential to coordinate care across Racine area service providers. As such, it is actively supporting intersystem collaboration and communication,¹³ a key implementation driver of trauma-informed care, and it is helping to translate trauma-informed care principles into practice.

References

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