

T-SBIRT

Improving the lives of those exposed to serious trauma

- Trauma can be considered a response to distressing life events or situations.
- Individuals exposed to serious traumatic events or situations can often experience difficulties in their everyday lives.
- Drawing from trauma-informed care (TIC) principles, Professor James 'Dimitri' Topitzes at the University of Wisconsin-Milwaukee, USA, has developed a new trauma screening, brief intervention, and referral to treatment protocol, known as T-SBIRT.
- Using an interview format, T-SBIRT can be readily integrated into health and human service settings and offers an opportunity to improve mental health for those exposed to trauma.

Trauma is a psychological response to a distressing event or situation, such as a serious injury, physical or sexual abuse, events of death or death threat, and intimate partner violence.

Trauma has a significant impact on a person's life. Those who go through such experiences can often have difficulties including anxiety, depression, and post-traumatic stress disorder (PTSD).

What is trauma-informed care?

Many health and human service agencies practice trauma-informed care (TIC), an approach to care that promotes a culture of safety, support, and healing. Care workers are trained to understand how trauma affects people and how it can trigger mental health conditions so that the professionals can interact with patients or clients sensitively, be transparent while involving them in their care, and offer appropriate support. TIC positively impacts patient and client outcomes through its potential to improve engagement in and adherence to treatment.

Drawing on TIC principles, Professor James 'Dimitri' Topitzes at the University of Wisconsin-Milwaukee, USA, created a tool called T-SBIRT (trauma, screening, brief intervention, and referral to treatment). T-SBIRT can help individuals exposed to traumatic events and situations by reducing their distress, making them aware of their experiences and reactions, providing them with support, and – if required – referring them for treatment. As Topitzes explains, 'T-SBIRT has two main aims, to help individuals gain insight into the extent and effects of their trauma exposure, and to enhance their motivation to engage in positive coping, such as seeking behavioural or mental health services.'

T-SBIRT

Topitzes adapted T-SBIRT for community trauma screening from a similar protocol – SBIRT (screening, brief intervention, and referral to treatment) for substance use. Both approaches combine best interviewing practice into a one-session intervention.

T-SBIRT is a standardised one-session protocol. It is client-centred and brief, only taking around 10 to 30 minutes to complete. As it is not complicated, it can be readily integrated into different health and

human service settings, including primary and specialty health centres, mental health treatment clinics, child welfare and social service agencies, and criminal justice facilities.

Initial studies promising

To test its strengths and weaknesses, Topitzes and colleagues carried out an initial feasibility study on 112 patients attending primary care clinics. The results were very encouraging – both participants and service providers complied with the process and most participants (63%) accepted referral for treatment.

The T-SBIRT protocol was then tested on 83 low-income urban adults within a private employment service programme. The T-SBIRT protocol revealed surprisingly high rates of trauma history (90%) with over one third of the individuals presenting with depression and about half experiencing PTSD. Importantly, following their T-SBIRT sessions, 75% of participants accepted a referral to mental health care or other services. Most participants, when offered, accepted the protocol, and all who agreed to participate in T-SBIRT completed the interview process.

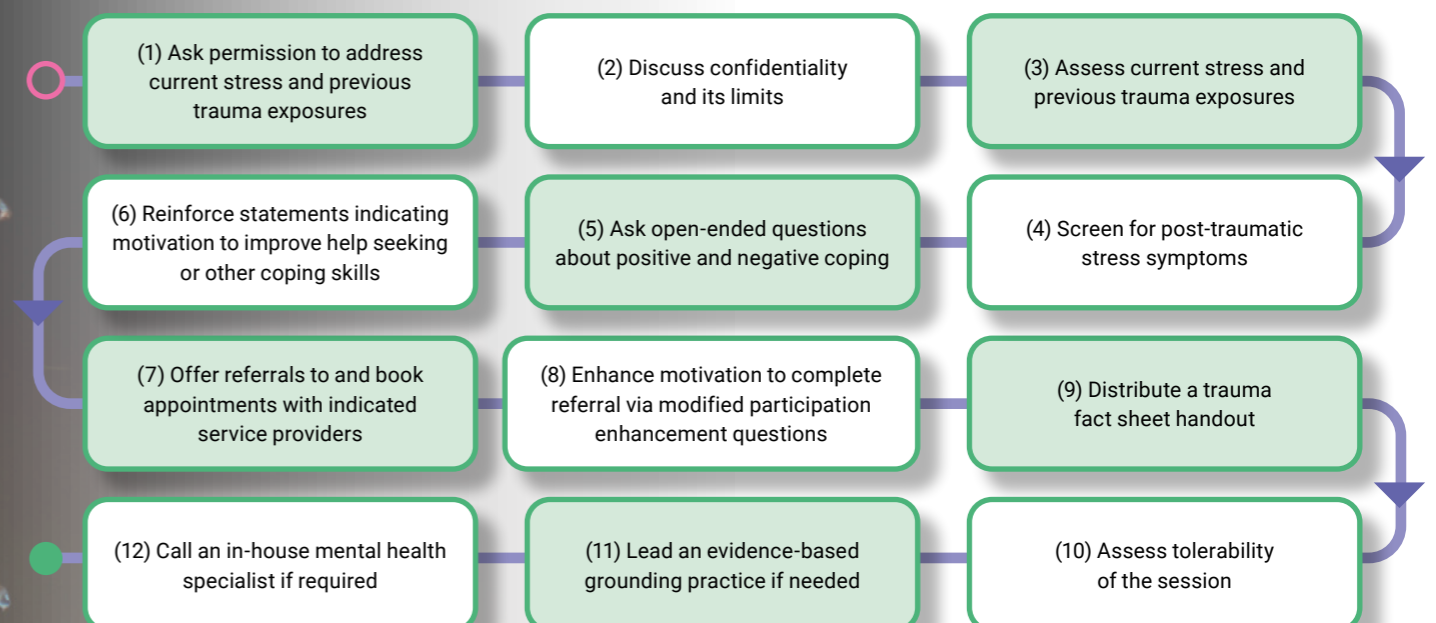
A third and larger study aimed to integrate the T-SBIRT protocol into a universal home visiting programme. Over 97% of the 698 participants offered T-SBIRT accepted, and of these, over 96% completed the protocol. Topitzes explains, '99% of participants reported feeling the same or better upon the conclusion of T-SBIRT, an indicator of tolerability. In addition, just under one third accepted a referral to mental or behavioural health care.'

Putting TIC principles practice

Building on the promising results from their pilot studies, Topitzes and colleagues developed the T-SBIRT protocol for use within a state-administered programme called Temporary Assistance to Needy Families (TANF). TANF offers financial assistance and opportunities for work, education, and training to individuals who cannot provide for their families. Many using the service are single mothers and have been victims of physical abuse, while a significant percentage have experienced mental health conditions.

A standardised one-session protocol, T-SBIRT is client-centred and brief, and can be readily integrated into different health settings.

A well-articulated integrity checklist facilitates T-SBIRT training and implementation and outlines the following protocol steps:





Trauma-informed care is an approach to care that promotes a culture of safety, support, and healing.

The TANF agents were trained to complete the necessary checklists and facilitate T-SBIRT sessions. The study lasted 1.5 years and involved 188 participants who completed an initial survey. A total of 88 participants completed the follow-up survey. Of these 88, 23 completed a T-SBIRT session (intervention group) prior to completing the follow-up survey while 65 participants did not complete the T-SBIRT process (comparison group). The research team used reliable tools for scoring anxiety and depression levels.

The results showed an adherence rate of over 98%, a much higher number than expected.

The researchers aimed to answer the specific question: How often did the T-SBIRT providers adhere to the protocol? The results showed an adherence rate over 98%, a much higher number than expected. The second question investigated the number of participants that found the process tolerable, which was 91%, higher than the bar previously set by the team (90%). Only one person reported feeling worse at the end of a T-SBIRT session, while over half of the intervention group felt better.

The study also highlighted a decrease in mental health symptoms in individuals who completed T-SBIRT.

The intervention group (T-SBIRT group) entered the study with slightly higher levels of depression compared to the comparison group. However, after the completion of T-SBIRT services, follow up survey results showed that the average T-SBIRT group depression score was lower than that of the comparison group.

Finally, the researchers investigated whether T-SBIRT completion is linked to a reduction in positive mental health screenings. The rate of positive depression screens for the T-SBIRT group dropped from over 60% at the beginning of the study to 48% after T-SBIRT. There were similar results for anxiety levels and PTSD rates – the higher PTSD scores observed in the T-SBIRT group reduced significantly more than the average comparison group.



Topitzes developed a new trauma screening, brief intervention, and referral to treatment protocol, known as T-SBIRT.

The future of trauma care

Importantly, T-SBIRT was found to be easy to use, helpful for the service users, and efficient when screening mental health conditions, making the team optimistic for its future use. The study demonstrates that T-SBIRT is a highly promising approach with the potential to enhance mental health outcomes. Topitzes concludes, 'Trauma-informed care grew out of a recognition that trauma exposure is both common and consequential and aligns services with various principles such as empowerment, choice, and collaboration. T-SBIRT translates these principles into trauma-responsive practices.'



T-SBIRT can be readily integrated into health and human service settings and offers an opportunity to improve mental health for those exposed to trauma.

Personal response

What inspired you to work on trauma-informed care projects?

Several insights contributed to my motivation to develop trauma-informed and responsive services. First is the recognition that exposure to various types of traumas is quite common worldwide. Second, I recognise that trauma exposures can predictably and insidiously affect functioning across the lifespan, in part by undermining critical coping skills such as help seeking. Finally, and perhaps most importantly, I have experienced the healing power of trauma-centred conversation. When talking attentively with people about their experience of adversity and trauma, I have noticed that the interactions often take on a very special, timeless quality and result in reported benefits. Many people, for instance, mention that the conversation buoys them by helping them acknowledge experiences of trauma, post-traumatic stress, and resilience. They also report that these conversations help them chart a new course for recovery and generate a greater sense of hope. I think that this type of work helps to unlock the power of healing in the service of human connection, community, and flourishing.

You developed T-SBIRT with a view to its integration into large systems of care and for it to be available to many. Can you tell us more about how T-SBIRT is set up to achieve this?

The following T-SBIRT features facilitate its uptake into large systems of care. First, T-SBIRT is conceptually simple and follows an intuitive topic sequence. Second, through the development of a detailed integrity checklist, T-SBIRT is well-articulated. Third, while well-outlined, T-SBIRT is semi-structured and allows for variation across contexts and sessions. To elaborate, T-SBIRT is a targeted universal model, meaning that it is available to all yet varies according to need, such that services are titrated based on participant presentation. For someone with a lengthy history of trauma exposure and pressing mental health needs, the protocol may last 30 minutes or even longer. Conversely, someone with few or no trauma exposures and no current mental health needs may only require ten minutes to complete the protocol.

Fourth, T-SBIRT is designed to be culturally sensitive. For instance, it empowers participants by encouraging them to refuse to answer questions if they so choose, posing open-ended questions that participants can answer any way they like, and soliciting participant preferences for referral. In addition, it explores participants' positive coping and resilience, in the spirit of asset framing.

Finally, T-SBIRT is open source. If an agency would like to receive training in T-SBIRT from the developer and his team, reasonable costs for personnel time are

involved. However, there are no charges associated with protocol materials such as the integrity checklist, and access to all T-SBIRT materials is freely available to all. In addition, the protocol is subject to structural modifications across sites. Some organisations or agencies may, for example, elect to drop the post-traumatic stress reaction screening component of the protocol and replace it with an open-ended question about trauma effects. We have not conducted feasibility or efficacy research on any modified versions of T-SBIRT, but we encourage agencies and their evaluation partners to do so if inclined.

T-SBIRT is a highly promising approach for the treatment of trauma. Do you think there is a place for T-SBIRT in the prevention of trauma?

There are several ways in which T-SBIRT could be used to prevent trauma exposure and/or trauma symptoms. By implementing T-SBIRT within two generation programmes such as nurse home visiting services or paediatric healthcare, parents can be educated about their own trauma exposures along with prevention of intergenerational trauma transmission. Modification of the T-SBIRT handout could help facilitate such goals as could the addition of an item or two within the protocol.

Prevention is also salient after trauma exposures. Around 70% of the general worldwide population reports exposure to at least one significant type of trauma across the lifespan, including difficult-to-avoid experiences such as natural disasters or traffic accidents. The development of persistent trauma symptoms, however, is not inevitable. T-SBIRT can help participants identify and strengthen positive coping, which could offer protection against trauma symptoms persisting in the aftermath of trauma exposure. This is a hypothesis that warrants further attention, for instance within emergency healthcare settings.

What are your future research plans regarding T-SBIRT?

Following the promising results of the recent quasi-experimental study in which T-SBIRT completers showed significant improvements in mental health outcomes relative to non-completers, we are interested in conducting a randomised control trial to increase confidence in T-SBIRT's mental health implications. We would also like to extend outcomes beyond mental health, into outcomes relevant for settings such as healthcare and workforce development.

How can healthcare providers learn more about implementing T-SBIRT?

Please contact the T-SBIRT author, James 'Dimitri' Topitzes (topitzes@uwm.edu) or access the following website: uwm.edu/icfw/trauma-sbirt

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Bio

James 'Dimitri' Topitzes, PhD, is a social work professor and department chair at the University of Wisconsin Milwaukee. He also serves as the Director of Clinical Services for the Institute for Child and Family Well-Being. He conducts applied research, partnering with community agencies to implement and test innovative trauma-responsive programmes.

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Collaborators

- Joshua P Mersky, PhD
- Lisa Berger, PhD

Further reading

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