Title: Promoting SBIRT Training for Social Work Students Across Field Settings

Short title: Promoting SBIRT Training

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Key words: SBIRT training, field settings, field supervision, SBIRT implementation, interprofessional education.

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The Northwest Leaders in SBIRT (NL-SBIRT) Program represents a partnership of the University of Washington School of Social Work and King County Division of Behavioral Health and Recovery, along with the University of Washington Schools of Nursing, Pharmacy, and Dentistry, supported by primary care and integrated behavioral health organizations across the region. Funding provided by SAMHSA-Grant No. 1H79TI025935-01,"Screening, Brief Intervention and Referral to Treatment (SBIRT) Health Professions Student Training" Grant.

Abstract

We report on our experience of implementing an interprofessional social work SBIRT training program in which didactic content was integrated with field education opportunities to practice SBIRT in various practice settings. Mentored field instructors supervised SBIRT field learning activities in behavioral health clinics, primary care clinics, inpatient and outpatient psychiatry and mental health and addiction service settings. Input regarding program implementation was gathered from students and field instructors. Student use of SBIRT varied by field setting. We report on field instructors' perceptions of site-specific challenges to successful implementation of SBIRT and describe lessons learned for social work training programs.

Introduction

Alcohol use is the seventh leading risk factor for death and is a major contributor to the global burden of disease (Burton & Sheron, 2018; Forouzanfar, & GBD Risk Factors Collaborators, 2015). In 2014, an estimated 17 million individuals in the United States were classified as having an alcohol use disorder (Putney, O'Brien, Collin, & Levine, 2017; Substance Use and Mental Health Administration (SAMHSA), 2015). Treatment for substance use disorders has traditionally concentrated on populations with severe problems, but efforts now also focus on the prevention of risky and harmful drinking. One such approach, Screening, Brief Intervention, and Referral to Treatment (SBIRT), is an evidence-based intervention that identifies individuals who are at risk but do not meet criteria for an alcohol misuse diagnosis. SBIRT has been shown to prevent alcohol misuse among adults (Mitchell, Broyles, Pringle, Kraemer, Childers, Buranosky, & Gordon, 2017) and is being integrated into a variety of health care settings as part of a public health approach to the problem of substance misuse.

While SBIRT services may be effective in reaching people at risk for harm from alcohol use in primary care (Pilowsky & Wu, 2012; Rahm, Boggs, Martin, Price, Beck, Backer, & Dearing, 2015) the widespread implementation of SBIRT is dependent on access to professionals who are skilled in its use in a range of health and social service settings (Agerwala & McCance-Katz, 2012; Madras, Compton, Avula, Stegbauer, Stein, & Clark, 2009). Social workers provide more behavioral health services than any other profession (Gordon & Alford, 2012), and are present in a wide-range of community-based settings where screening and brief interventions are relevant. Yet most social work training programs and clinicians in the field do not have in-depth training in SBIRT and its underlying skills in motivational interviewing and interprofessional collaboration (Ogden, Vinjamuri, & Kahn, 2016; Smith, Egizio, Bennett, Windsor, & Clary,

2018.). This report describes the efforts of a school of social work in partnership with a regional public health division to develop and implement an interprofessional SBIRT training program for health services graduate students and their practicum field instructors. Using implementation data on skill use from students and program evaluation feedback from field instructors, we describe our experience and the challenges we faced in creating a training program and implementing SBIRT across different field settings to aid other social work programs in training students in evidence informed interventions such as SBIRT.

Although SBIRT was initially developed for primary care, it is appropriate for a broad range of health and behavioral health settings because it is a brief intervention that can be implemented with relative ease. By providing universal screening and brief interventions, SBIRT can help to reduce the harm associated with alcohol use and provide timely assistance to individuals with possible alcohol use disorders (Babor, McRee, Kassebaum, Grimaldi, Ahmed, & Bray, 2007; Madras et al., 2009; SAMHSA, 2013). SBIRT programs can help interrupt the progression from problematic drinking to an alcohol use disorder. The evidence for brief interventions such as SBIRT has been well-documented particularly for harmful drinking and training in this evidence-informed intervention is now spreading beyond early implementers such as physicians/providers (O'Donnell, Anderson, Newbury-Birch, Schulte, Schmidt, Reimer et al., 2014; Bien, Miller, & Tonigan, 1993; Kahan, Wilson, & Becker, 1995).

Training social workers to be both well versed in knowing the effective practice of SBIRT and the potential limitations of the approach in behavioral health settings is important. While a multidisciplinary effort and cross-sector collaboration will be necessary to address alcohol misuse, social work is key to this effort as social workers are the most frequent first point of contact for mental health and social service delivery across a wide range of sectors (Wilkey,

Lundgren, & Amodeo, 2013), including medical, behavioral health and social service, criminal justice, and education (Begun, Clapp, & Alcohol Misuse Grand Challenge Collective, 2016)).

In addition to social workers meeting the growing need for service providers, the profession has a key role to play in refining educational models for workforce preparation and developing practice training standards (Spencer & Walters, 2016). With federal support from SAMHSA, schools of social work are doing just this. Although many educational programs are in their early stages and still reporting preliminary findings, a growing literature on SBIRT training models and programs is helping to inform the development of SBIRT and addictions curricula and competencies for social work training and helping to identify implementation challenges and facilitators (Childers, Broyles, Hanusa, Kraemer, Conigliaro, Spagnoletti, McNeil, Gordon, 2012; Hoge, Migdole, Cannata, & Powell, 2014; Osborne & Benner, 2012; Putney et al., 2017; Smith et al., 2018; Wike, Bledsoe, Manuel, Despard, Johnson, Bellamy, & Killian-Farrell, 2014)).

Developing the SBIRT training program

Given that integration of classroom- and field-based coursework is central to social work's pedagogy, our social work SBIRT training program integrated coursework and field practicum opportunities to prepare students with the necessary knowledge, skills, and experience to work with individuals who are at risk for suffering harm from their use of alcohol. Our institution also has a demonstrated commitment to and expertise in Interprofessional Education and Practice (IPE/IPP). [Institution name withheld for blind review] is one of the few social work programs in the country to be administratively linked at the university level to other health professional programs. Our social work school is one of six schools in the Health Sciences Division along with the Schools of Medicine, Nursing, Pharmacy, Dentistry and Public Health.

Consistent with the social work literature describing the combining of didactic content and supervised practice of an empirically supported intervention as the "gold standard" in education (Bledsoe-Mansori, Bellamy, Wike, Grady, Dinata, Killian-Ferrell, & Rosenberg, 2013), our SBIRT training program was aligned with our MSW curriculum to include both coursework and SBIRT practice opportunities within supervised field placements. The program also sought to capitalize on our strength in IPE/IPP to prepare social workers and other health professionals for interprofessional team work by recruiting team-based field practicum experiences and case-based, interactive joint classroom activities. Next we describe steps we took to develop SBIRT field placements, and we briefly outline the classroom curriculum and interprofessional opportunities in our SBIRT program.

SBIRT social work field education

For MSW students, field placement sites provided supervised practice experience in conducting screening, brief intervention, and referral to treatment for alcohol misuse. Sites in our SBIRT program included primary care settings, emergency departments, hospitals, community mental health clinics, dental offices, and other community service organizations in the region. Prior to the selection of practicum placements as a location for SBIRT trainees, site visits were conducted by the project director and a field education faculty member to ensure students would have opportunities to practice SBIRT and to assess the needs for field instructor support to supervise students in MI and other core skills. Table 1 provides an overview of the types of field placement sites. The majority of students were placed in free-standing primary care and behavioral health settings. Over the course of the 3 year SBIRT program, we placed students in 17 different field sites, with 22 field instructors participating. Field instructors typically supervised between 1-3 students; sometimes students had more than one field supervisor. The

field instructors were a seasoned group of practitioners with between 4 and 20 years of experience as professional social workers and 2 – 10 years of experience as field supervisors. Social Work students who were selected received a $5000 scholarship to support their participation in SBIRT classes and field practicum.

<insert Table 1 here>

In evidence-supported interventions such as SBIRT, effective supervision requires field supervisors who are trained in the intervention and who are also mentored in the practice of supervision (Hoge et al., 2014). Beyond the standard training and support that all Field Instructors receive, the FI's who participated as supervisors in our SBIRT Program received additional training, mentorship, financial compensation, and group support to address the increased expectations related to FI learning. With funding from SAMHSA, and in partnership with our regional public health office, our program provided a free 2.5 day training in motivational interviewing and SBIRT for those field instructors recruited to supervise SBIRT social work students and other community social workers. Field instructors also received an annual $1,000 stipend per student they supervised to defray costs of continuing education to support their ongoing professional development. We also provided field instructors with ongoing mentorship through the efforts of a Field Faculty member who was the liaison between the school's Field Education Office, the project team, students and field instructors. The Field Liaison conducted outreach to recruit sites and field instructors, and provided orientation to field supervision, on-going advising and guidance, and regularly scheduled group meetings to address challenges to implementing the SBIRT program at the field agencies. Once sites were selected, quarterly meetings were conducted with the field instructors and field education faculty.

Meetings were well attended and offered field instructors the chance to learn from one another as well as share experiences with facilitating SBIRT practice opportunities for their students.

Students received targeted support from the field liaison to attain the practice objectives of the field learning contract. Social work students were often part of interprofessional teams that included physicians, advanced practice nurses and others in their field placements. The Field Liaison oversaw the development of standardized field learning contracts across settings providing SBIRT placements. In individual meetings at the agency, this learning contract was further individualized to meet the needs of each learner and in recognition of opportunities or challenges present at the agency. In addition, after the first year of the program, the Field Liaison co-taught the integrative seminar (described below) to ensure that issues in field placements were promptly identified, and to support the integration of the curriculum with field experiences.

Content in the classroom

Our SBIRT program built from the MSW foundation and health and mental health concentrations already available at the school. Three areas of curriculum modification were made and are summarized in Figure 1.

<Insert Figure 1 here>

First, we strengthened content that all health and mental health students received around the use of common mental health screening instruments. Students also received introductory training in motivational interviewing, with a focus on improving listening and reflection skills and ways to assess the student's own therapeutic behaviors; trainees also received a unit on the use and ethics around electronic health records. Next, we created an SBIRT course that provided information on interprofessional management of substance use, oriented students to basic medical, social and behavioral aspects of substance misuse and detoxification procedures, and

provided content on motivational interviewing. The final component to the SBIRT classroom curriculum was an in-depth, skills-oriented integrative seminar for SBIRT trainees, both from social work and other disciplines. The seminar provided an overview of the biopsychosocial effects of alcohol use and provided support for practicing skills, as well as an opportunity for interprofessional teams to present a case studies, with a special emphasis on ways to advocate for SBIRT across systems.

Inter-professional education (IPE) in our SBIRT Program

Our program built on already existing collaborations between the Health Sciences Schools at our institution to present IPE/IPP educational activities. We recruited trainees from Nursing (n=4), Dentistry (n=9) and Pharmacy (n=8) to provide social work students the opportunity to learn with and from their interprofessional colleagues. With support from our federal grant, nursing, dentistry and pharmacy students received a $1000 stipend for participation in the SBIRT course and integrative seminar. Across the three years of the program, 33 Social Work students and 21 interprofessional students participated in the SBIRT training program. The majority of the trainees were female (78%); 74% were age 21-30 years, 20% were between 31-40 years, and 6% were over 40 years of age. Approximately 2% identified as Black or African American, 13% Asian, 2% as Native Hawaiian or Pacific Islander, 2% Native American, 62% White, and 18% did not identify their race. These demographics are proportional to the student population in the Health Sciences departments at [Institution].

Implementation Feedback from Students

Our preliminary follow-up data show that, one year post-graduation, most social work trainees were working in settings that did not routinely use SBIRT (63%). Yet, over 90% of social work graduates indicated that they apply the skills learned through their SBIRT training in their clinical practice. Students have identified the use of motivational interviewing, screening

systems, and referral resources as important skills, as well as being able to conduct a brief negotiated intervention. This suggests that SBIRT training programs offer valuable skills that are applicable across a range of clinical settings.

Table 2 presents data from social work trainee encounter types by field placement setting. Data on SBIRT encounters were only available for the latter two years of our program (Years 2 and 3), during which time 25 MSW students were trained. As evident from the data, the placements were successful in providing social work students with experience in all aspects of SBIRT. Data on encounters were gathered across the final two quarters of the students' field education experience. Across that time frame, 25 MSW students screened a total of 486 clients, conducted 288 brief interventions, and referred 278 clients to services. MSW students in community mental health settings averaged a total of 50 screenings, compared with 18 and 11 in primary care centers and hospital settings, respectively. In addition to variation in the amount of student opportunity to practice SBIRT screening by field setting, rates of student experience delivering brief interventions differed, as did the average number of referrals they made while in their practicum. For example, on average, students placed in primary care settings reported conducting a total of 14 brief negotiated interviews and made 13 referrals across their final 2 quarters. In hospital settings, on average, students reported conducting a total of 9 brief interventions and making about 10 referrals in that time period. In community mental health clinics, MSW students reported conducting only 7 brief interventions and making 5 referrals. These data indicate that students in community mental health settings had more opportunity to practice screening compared to students placed in hospitals or primary care settings, but had less experience with brief negotiated interviews and referrals for treatment. As shown in the table, student experience with direct follow up after referral was relatively limited across all field

placement settings. In presenting these data, we note that these represent student reports of their experience with brief interventions, referrals, and follow up activities regardless of whether they had conducted the original screening, thus these are reports of student experience with different aspects of SBIRT rather than client-level data. We also recognize that most of these practicum sites served high-risk populations, some of whom did not need the screening and were simply given a brief negotiated interview and / or referral to treatment. It is therefore not clear what percentage of SBIRT screenings led to brief negotiated interviews, or what percentage resulted in referrals to treatment. National data indicate that over 25% of screened individuals would meet the criteria for a brief intervention (as reported on the Washington SBIRT screening card); future research might explore this rate across different practicum placement settings.

<Insert Table 2 here>

Program Evaluation Feedback from Field Instructors

As part of our ongoing program evaluation activities, we obtained information about implementation of the SBIRT training via discussions with field instructors, both in individual meetings and in quarterly group meetings. Field instructors also provided written feedback about the facilitators and barriers to creating SBIRT-oriented field placements via a program evaluation survey emailed to them after the final group meeting. Feedback from Field Instructors informed program revisions throughout the program, and helped surface challenges to implementing SBIRT training across field settings.

Input from Field Instructors helped to refine the program and curriculum in its early stages. For example, in the first year of the program, field instructors identified three content areas that social work students needed to be successful in their SBIRT practice. First, was a solid foundation of knowledge about substances and substance misuse. Second, was a need to be

well versed in motivational interviewing. Beyond the knowledge of MI, they suggested that it was the "spirit" of MI that was critical for students to practice. Finally, Field Instructors underscored that students needed a good understanding of evidence informed treatment strategies, including treatments related to co-occurring disorders like dialectical behavioral therapy and cognitive behavioral therapy. Based on this feedback, the training components evolved over the implementation of the program to better meet the needs of diverse students. For example, the timing and intensity of the integrative seminar was altered—originally it began in winter quarter. We shifted the seminar so it book-ended the SBIRT course, and integrated more substantive information on alcohol and drug misuse and screening tools earlier in the curriculum. The SBIRT course was originally offered in the spring, but was shifted to winter quarter in order to better prepare students in placement settings with motivational interviewing practice content they needed to conduct SBIRT. The integrative seminar also evolved into a focus on students providing case presentations from their field practice sites.

Challenges and lessons learned in implementing social work SBIRT training across settings

Based on our experience implementing our SBIRT training program and coupled with program evaluation input from field instructors, we describe implementation challenges in three key areas: 1) general barriers to implementing population-based screening and early identification of risky drinking, 2) difficulties stemming from varying levels of organizational and system support for SBIRT, and 3) challenges to implementing SBIRT social work training and lessons learned regarding SBIRT in social work field education.

Implementing population-based screening

Agencies experienced several challenges to implementing the early intervention focus that SBIRT is predicated upon, including lack of clarity about basic procedures, such as who

would administer the screening. We observed that, across the different agencies, the methods for implementing SBIRT in the clinical setting varied considerably. For instance, both within and across settings, different professionals and workers were responsible for administering SBIRT screening questionnaires. Some sites used social workers, others used medical assistants (MAs), physicians, front desk staff, or nurses to administer SBIRT surveys. One social work field instructor described the complexities that arose within their system when they tried to implement screening across the entire population of their program:

> *"I work in a primary care clinic and …initially the front desk was handing out the assessments, but we had a lot of instances where patients would write, "Why am I getting this questionnaire?" The front desk staff felt uneasy explaining it, so we moved it to the medical assistants and then the MA's started to get overwhelmed with all of the different, equally important things they were supposed to ask…*

In this primary care setting, time pressures and competing responsibilities contributed to the staff being overwhelmed, which amplified the challenge of implementing the screening in the setting. In addition to the challenge of identifying who is responsible for administering the screening, we found that, even when responsibilities were clearly defined, with back-up plans in place, implementation might be still be incomplete.

This variation at the front-end of the SBIRT process showed the difficulty some sites experienced in implementing population-based screening. Although MA's and front desk staff saw all patients, and so were natural people to ensure the screening occurred, in actuality, the number of demands placed on these staff and their inexperience with substance abuse meant that screening didn't occur consistently. As a result of these patient flow issues, some programs reverted back to only using the screening questionnaires when they suspected the person had a

drinking problem. Without the population-based screening, practitioners were unlikely to identify people at risk for suffering harmful consequences from their alcohol use. Students in these settings were not able to consistently work with people whose screening results indicated they were at risk of experiencing harm related to their drinking behavior.

For certain settings, another challenge in implementing SBIRT screening universally was the sheer number of clients with substance problems. One field instructor described her role in a hospital setting and the challenges to administering SBIRT among populations that present with concerns of excessive use or misuse of substances.

> *I think in my setting, because it is specifically an SBIRT position, one of the tough things for us is that 97% of people meet severe alcohol dependence criteria. It's such a stacked deck. We're referring everyone to treatment. It's just a really different demographic. It seems kind of silly to administer the AUDIT with this population when they've told you that they drink a fifth a day.*

In this situation, providing adequate training to students was also difficult because patients were already seriously ill and needed more than a brief motivational intervention. Although this offered students a chance to practice skills in referring patients to treatment, the limited availability of treatment slots meant that many clients could not be served.

Organizational and system support for SBIRT

Effective implementation of population-based SBIRT screening in health and social service settings requires organizational buy-in and structured supports (e.g., insurance coverage, reimbursements). In addition to having important roles in delivering SBIRT, social workers applied their systems change skills to support advances in practice and policy. One field instructor described how the role of the social worker in a primary care clinic moved beyond

administering SBIRT to promoting SBIRT and increasing system-wide support. As she said, *"I am able to talk to individual providers, and that has increased the uptake of SBIRT in that setting -- to the extent even that SBIRT screening has since become a required part of clinic services."*

One basic challenge encountered was disagreement among some practitioners about SBIRT's effectiveness. One field instructor observed that not all of her colleagues saw SBIRT and motivational interviewing as effective or necessary. In primary care settings, promoting SBIRT, especially to physicians, was important to ensuring consistent use of the approach. One field instructor described the experience of a physician colleague who initially didn't think he needed to do the screenings because he knew his patients well enough, but when one of these patients he thought he knew well scored very high on the AUDIT screening tool, the physician was convinced of the importance of SBIRT.

Field instructors recruited to supervise social work students in our SBIRT program were often early adopters in their organizations and champions of this public health approach to preventing alcohol misuse and its consequences. Yet, not all practiced within organizations that valued the integration of SBIRT into practice. At quarterly meetings, field instructors shared their experiences with varying levels of organizational and system support. Our program's Field Faculty Liaison and Project Director provided perspective and field instructors offered peer support on how to address this barrier to the broad implementation of SBIRT. Field instructors agreed on the importance of sharing compelling findings about outcomes and engaging the top leaders within the agency to increase buy-in. As our field instructors underscored, outcomes of interest to administrators may include financial ones. Policies and systems that support the implementation of SBIRT, such as those that affect health care reimbursements have the potential to significantly expand the reach of this intervention. One member of our SBIRT

program and a regional trainer considered how this could be the case and the system wide implications for training health care professionals in MI and SBIRT:

> *I'm just thinking as a motivational interviewing trainer what could possibly be the reasons that people have trouble with MI? and I wonder if it's really about… I mean you can go to training but how do you really learn MI? It's really about practicing and getting coaching and I wonder if that's really hard to get paid for because it's not reimbursable.*

Field instructors discussed these system-level issues with students who were able to see the real-world effects of system buy-in either in their own practicum placements, or through information shared by other trainees in the seminar and SBIRT class. The organic emphasis that developed around the system issues was translated into changes in the curriculum as we integrated sessions on addressing system issues to both the course and integrative seminar.

SBIRT and social work field education

One of the first challenges we addressed in developing this training program was recruiting practicum sites that provided ample opportunity for social work students to practice SBIRT. We were successful in recruiting 17 different placement sites, yet overall, as we have reported above, we found great variation in how much opportunity students had to use the SBIRT and motivational interviewing skills they learned in their classes, in both primary care and other settings. Social work students in their concentration year at [Institution] are typically in field education for 24 hours a week across 30 weeks. Our student SBIRT encounters data (Table 2), which totals all encounters across a 20 week period, indicate that, on average, our MSW trainees reported spending a total of about 490 minutes (8 hours) practicing SBIRT skills with an average of about 19 clients. Sites offering more practice opportunities also tended to be

ones in which there was more practitioner autonomy and in which MSW students were empowered to follow up with patients previously screened and/or referred to treatment services.

Field sites and Field Instructors needed significant support. In our experience, providing active support of the field supervisors and giving them opportunities to share their experiences in implementing SBIRT and supervising students proved to be critically important. In addition to valuing the support and mentorship provided by our Faculty Field Liaison and Program Director, field instructors valued one another's insights and validation tremendously. In our final survey of the field instructors, they all noted their appreciation for the opportunity to learn from one another how they might overcome obstacles to provide more SBIRT practice and to strengthen practice opportunities for students at their sites. This type of peer support among field supervisors may facilitate the expansion of SBIRT activities within and across health and social service organizations, but it is challenging to maintain without active resources, such as our field liaison and program staff, and our federal grant, which supported all elements of the program. Going forward, organizations and agency leadership will play a critical role in building formal and peer supports to foster a "culture of innovation and supervision" in which the necessary time, resources and preparation permit effective supervision of students (Hoge et al., 2014). In their study of evidence-based practice partnerships between agencies and universities, Bledsoe-Mansori, et al. (2013) identified as a barrier the lack of expertise in evidence based practice (EBP) and evidence supported interventions (ESI) among key faculty and staff, including in field offices. We had the great benefit of having a knowledgeable Field Faculty Liaison, trained in EBP/ESI's who was able to effectively recruit and support sites and champion SBIRT.

Social work students in our training program benefitted from the opportunity to pair didactic SBIRT content with supervised practice in the field. Student input underscored the value

of this concurrent learning model. This is consistent with findings reported by Putney et al., 2017), who held that paired instruction and supervision in the field would strengthen social work students' ability to integrate SBIRT in their practice with those who misuse alcohol. However, among the challenges we encountered in implementing our SBIRT training program as an interprofessional education endeavor was that the various disciplines structured their academic coursework and field experiences differently, and not all were scheduled concurrently, as our social work program is structured. Because of this, only social work students had the field education placement while they were taking the SBIRT course and seminar, and this meant that the students from other disciplines did not have a chance to practice SBIRT skills concurrently in clinical settings.

Structural support was also important to providing strong practice opportunities. One key support was the ability of the field education site to bill for SBIRT services. Organizational factors and the way that teams functioned together were also perceived as affecting student opportunities to practice SBIRT. In settings with more severe time and workflow constraints on patient care, students had fewer opportunities to practice skills. Field settings that structured warm handoffs to social work students to conduct SBIRT had more success in moving patients from screening to brief intervention, providing students with greater opportunities to practice these core skills.

In sum, our experience developing an SBIRT training program for social work students taught us important lessons that inform our thinking about future such initiatives. First, the recruitment and support of field placement sites and field instructors was critically important; second, structuring the training to pair the didactic content with opportunities to practice MI and SBIRT in supervised settings and with a concurrent integrative seminar was an effective model;

third, organizational and systems support for using SBIRT was important to ensure strong practice opportunities across different settings (e.g., the ability to bill Medicaid for SBIRT services); and finally, it was important that project staff promote the utility, value, and effectiveness of SBIRT in those sites where there may be reluctance to implement SBIRT.

Conclusion

Social work has an important role to play in reducing and preventing the misuse of alcohol. Skills to engage and intervene with substance misusing clients are critical for social workers, who practice on the frontlines in a wide range of health and social service settings. Our experience uncovered implementation challenges and offers important lessons about designing SBIRT training programs for social work students. Among these is an acknowledgement of the power of interprofessional education, training, and collaboration – we found it important for MSW students to learn from other professions and vice versa. To advance rigorous preparation of social work practitioners it is also critically important to develop, train, and support field placement sites and supervisors and promote organizational and structural supports.

Table 1

Students and Field Instructors by Type of Setting

	MSW students		Field instructors	
Agency Setting	N	%	N	%
Free Standing Primary Care Behavioral Health Clinics	13	52%	11	52%
Hospital Based Clinics and Inpatient Programs	9	36%	9	43%
Community Mental Health Programs	3	12%	2	9%
Total	25	100%	22	100%

Table 2

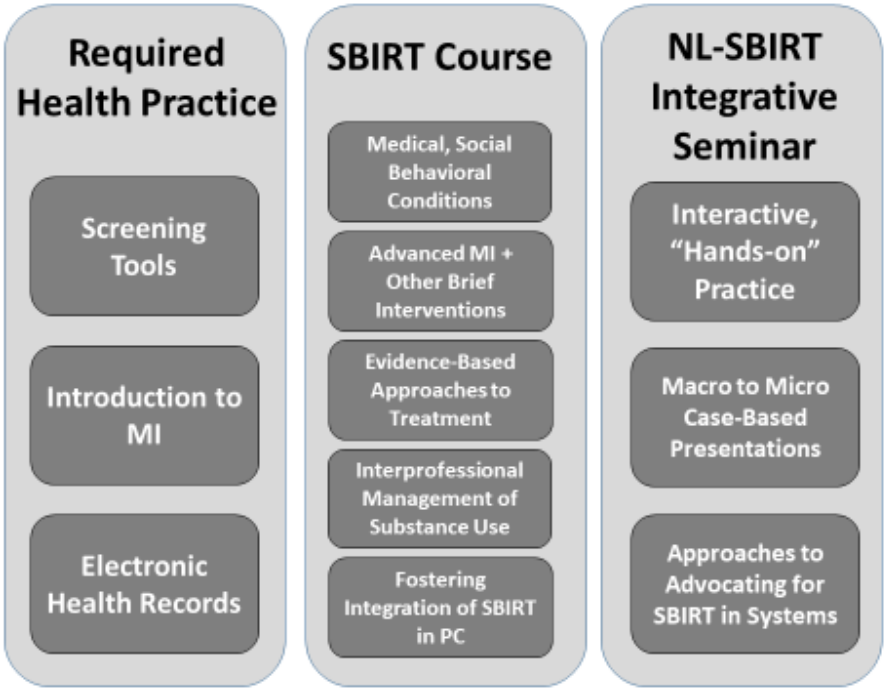
SBIRT Encounter Types by Setting for Years 2 and 3 (N=25 MSW students)

SBIRT Activities	Free Standing Primary Care Behavioral Health Clinics (13 students)		Hospital Based Clinics and Inpatient Programs (9 students)		Community Mental Health Programs (3 students)	
	Σ	*M*	Σ	*M*	Σ	*M*
1) How many Patients did you screen using an approved SBIRT screening tool?	238	18.3	97	10.8	151	50.3
2) How many Brief negotiated interviews did you conduct?	183	14	84.	9.3	21	7
3) How many of those screened did you refer to other services?	170	13	92	10	16	5
4) How many patients did you follow up with post referral?	59	4.5	31	0.3	2	1

5)	How many minutes did you spend on SBIRT related activities?	6872	528.6	4225	469	1215	405
6)	How many hours did you spend on SBIRT related activities	114.5	8.8	70.4	7.8	20	6.8

Note. M=Mean. Σ = Sum

Figure 1. Overview of SBIRT Training



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