Arctic SBIRT Training, 2013-2017

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Acknowledgements

The Arctic SBIRT Training would like to acknowledge the work and advice of the following people and entities: our Council of Directors; the faculty who worked with us to integrate SBIRT into their courses; the staff of the College of Health Interprofessional Health Sciences Simulation Center; our graduate and undergraduate student assistants; our consultant, Dr. Jason Satterfield; and our SAMHSA project officers Erich Kleinschmidt and Robert Day.
Executive Summary

In the fall of 2013, the UAA Center for Behavioral Health Research and Services (CBHRS) was awarded a three year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to prepare Alaska’s workforce to provide early identification and intervention for substance misuse through the use of screening, brief intervention, and referral to treatment (SBIRT).

Objectives
1. Adapt and implement SAMHSA’s SBIRT curriculum within programs in the School of Nursing, School of Social Work, and the Department of Psychology, and the Alaska Family Medicine Residency;
2. Increase collaboration among campus partners around SBIRT learning and program integration;
3. Assure students are provided with SBIRT education that is relevant to their discipline and also rurally tailored and culturally and linguistically appropriate;
4. Disseminate SBIRT education to expand the reach of SBIRT to a broader number of disciplines;
5. Disseminate SBIRT-related stories to increase adoption of SBIRT in clinical settings;
6. Establish institutional policies to sustain the inclusion of the SBIRT curriculum as a component of graduation requirements.

Partners
- University of Alaska Anchorage
  - College of Health
    - Interprofessional Health Sciences Simulation Center
  - Department of Psychology
  - School of Nursing
  - School of Social Work
- Alaska Family Medicine Residency
  (Providence Alaska Family Medicine Center)

- State of Alaska Division of Behavioral Health
- Yukon-Kuskokwim Health Corporation Sobering Center
- State of Alaska Public Health Nursing
- Consultant: Dr. Jason Satterfield, University of California San Francisco

Students Reached
The estimated total unique number of students or residents reached overall and by discipline during the implementation period is shown below. The implementation period ran from Spring semester 2014 through Fall semester 2016.

Table 1 Number of students reached overall and in each discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Program(s)</th>
<th>Students reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>AAS/BS/MS</td>
<td>511</td>
</tr>
<tr>
<td>Psychology</td>
<td>MS/PhD</td>
<td>53</td>
</tr>
<tr>
<td>Social Work</td>
<td>BSW/MSW</td>
<td>112</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Residency</td>
<td>33</td>
</tr>
</tbody>
</table>

Nine semesters (Spring 2014-Fall 2016)
Four target disciplines: 709 estimated unique individual student/residents reached
Some students received SBIRT on multiple occasions in different courses. This number was calculated after removing obvious duplicates.

**Implementation**
Faculty were provided with the standard SAMHSA curriculum in Fall of 2013. In response to requests from faculty, training and additional technical assistance in delivering the curriculum were offered to faculty in the summer of 2014, and fall of 2015 and 2016. All materials were made available to participating faculty through UAA’s learning management platform, Blackboard. There modified curriculum materials and resources were uploaded and then easily copied to each faculty member’s courses.

Observations of classes to determine fidelity to the original curriculum and subsequent adaptations were made in the first four semesters of the program. In later years, follow-up and communication with faculty were conducted by email and telephone to reduce the burden during class time.

The Family Medicine Residency program and the graduate level courses in each discipline used the Interprofessional Simulation Center to practice SBIRT-based skills using standardized patients and case studies.

*Table 2 Courses with SBIRT content integrated*

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Courses with SBIRT content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>NS 250 Psychiatric Nursing (AAS)</td>
</tr>
<tr>
<td></td>
<td>NS 401 Health Disruptions II (BSN)</td>
</tr>
<tr>
<td></td>
<td>NS 663 Family Nurse Practitioner IV (MS)</td>
</tr>
<tr>
<td></td>
<td>COHI 478/678 Interdisciplinary Explorations of Critical Behavioral Health Issues in AK (Interdisciplinary Elective)</td>
</tr>
<tr>
<td>Psychology</td>
<td>PSY 665 Psychotherapy Practicum (MS)</td>
</tr>
<tr>
<td></td>
<td>PSY 682 Clinical Interventions for Substance Abuse (MS)</td>
</tr>
<tr>
<td></td>
<td>PSY 652 Practicum Placement I (PhD)</td>
</tr>
<tr>
<td></td>
<td>COHI 678 Interdisciplinary Explorations of Critical Behavioral Health Issues in AK (Interdisciplinary Elective)</td>
</tr>
<tr>
<td>Social Work</td>
<td>SWK 440 Social Work Practice in Addictions and Mental Health (BSW)</td>
</tr>
<tr>
<td></td>
<td>SWK 459 Social Work Practicum II (BSW)</td>
</tr>
<tr>
<td></td>
<td>SWK 630 Practice Skills Lab (MSW)</td>
</tr>
<tr>
<td></td>
<td>SWK 633 Direct Practice II (MSW)</td>
</tr>
<tr>
<td></td>
<td>SWK 651 Social Work in Addictions and Mental Health (MSW)</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Psychiatry rotation</td>
</tr>
</tbody>
</table>

**Materials and Tools Developed**

Curriculum Infusion Package (CIP) and the *SBIRT Roadmap for Faculty*. Feedback from faculty led to the creation of the Curriculum Infusion Package (CIP) to assist faculty with little to no prior experience with SBIRT to integrate materials into their courses. It consists of three modules based on the time available for teaching SBIRT (60, 90, and 120 minutes) plus reading and
audiovisual materials, quizzes, and suggested assignments. The *SBIRT Roadmap for Faculty* is a companion to the CIP that can be used by faculty who wish to customize their delivery of the SBIRT curriculum. It is an Excel spreadsheet comprised of five tabs, one for each of the original SAMHSA sessions. Each tab has a list of learning objectives and materials and resources that address those objectives. The CIP and the Roadmap have been uploaded to Blackboard, to Google Drive, and to Office 365.

**Case Studies.** Case studies were developed to represent the types of clients/patients or situations health care providers in Alaska were likely to encounter. Six case studies per discipline were developed and tested by faculty in their classrooms or in the Simulation Center, and adjustments were made where necessary. See Appendix 2 for a list of these case studies.

**SBIRT Student Algorithm.** We developed a one-page color-coded guide, the *SBIRT Student Algorithm*, that provides phrases and directions for students to conduct SBIRT in their role plays and in the Simulation Center. Also included is a copy of the AUDIT US screening tool, standard drink size guide, a readiness ruler, and an alcohol use pyramid, all key items used to engage a patient or client in discussion. This tool was then made available to students in their classes and in the Simulation Center, and incorporated into the CIP.

**Skills Demonstration Videos.** We worked with UAA’s Academic Innovations and eLearning and the Simulation Center to create seven skills demonstration videos. Nursing, psychology, and social work each had two videos demonstrating skills and context specific to that profession. The seventh video was interdisciplinary, demonstrating each profession’s potential role in the SBIRT process from screening to brief intervention to receiving a referral for treatment. These videos are available on the Arctic SBIRT Training YouTube channel (www.youtube.com/channel/UCKLAAAQICFCl4aScpRDX-Nheqg).

**Outcome Evaluation**

**Student knowledge of SBIRT.** All disciplines demonstrated a significant increase in knowledge. Medical residents had the highest levels of knowledge before SBIRT training but also experienced the greatest increase after SBIRT training. Nursing students demonstrated the smallest increase in knowledge after training.

![Student knowledge of SBIRT increased](image)

**Student confidence to use SBIRT.** Trainees in all disciplines demonstrated a large and significant increase in confidence to use SBIRT skills for both alcohol and drugs. Medical residents had the
lowest levels of confidence before SBIRT training but experienced the greatest increases after SBIRT training.

**Student Perception of Responsibility to Use SBIRT in their Practice.** Small and in some cases non-significant changes in perceived responsibility to use SBIRT for alcohol and drugs were found across disciplines. Trainees endorsed high levels of responsibility to use SBIRT at baseline which left little room for improvement.

**Figure 2 Student confidence to use SBIRT increased**

**Figure 3 Student perception of responsibility to use SBIRT made small increases**
Student satisfaction with SBIRT training. Trainees indicated reasonably high levels of satisfaction with SBIRT training.

![Graph showing student satisfaction with SBIRT training](image)

**Figure 4 Students reported high satisfaction with SBIRT training**

Potential for Sustaining Training in SBIRT at UAA

1. The standard SAMHSA curriculum has been adapted to better fit the needs of faculty with a Curriculum Infusion Package that can be easily integrated into existing courses by faculty with little to no prior experience teaching SBIRT, as well as an *SBIRT Roadmap for Faculty* who wish to identify and use their own materials and resources to train the students in the SBIRT process.

2. Department chairs and faculty champions are invested in continuing SBIRT training in their programs and are actively pursuing mechanisms to support this.

Threats to Sustainability of Training in SBIRT at UAA

1. Program-level funding for the continued use of standardized patients in the Simulation Center needs to be identified and pursued.

2. Faculty are not required to train students in the SBIRT process as a permanent part of their courses, which may result in its extinction in the face of competing demands and/or faculty turnover.

3. In many of these programs, students are provided learning opportunities centered around what they will need to know when they enter their professional practice. While students consistently indicated they viewed SBIRT as part of their professional role and responsibility immediately following their SBIRT training in their courses, post-graduation surveys indicate a reduction in this perceived responsibility once they were in the workforce. Therefore weak adoption of SBIRT in practicum and practice settings may challenge the need to require it in the targeted programs.

Next Steps

- Identify and meet with key leaders such as the Dean of the College of Health, the Chair of the Department of Psychology, and the incoming Director of the School of Social Work to present a summary of program outcomes and challenges to sustainability.

- Explore a sustainable funding stream for the use of standardized patients at the Simulation Center with UAA leadership.
• Emphasize the alignment of SBIRT training with UAA’s workforce development goal to prepare students to meet the needs of diverse communities and improve health outcomes in future meetings with university leadership and stakeholders.

• Develop and implement a process for ensuring new faculty are introduced to SBIRT and the teaching resources available, such as the Curriculum Infusion Package.

• Develop and implement a system to ensure that students who are SBIRT-trained will be applying those skills in field and practicum sites by aiming to place them in clinics or agencies that have already implemented SBIRT.

• Provide opportunities for graduate students to formally evaluate SBIRT training and education in their programs as part of a course project or future assistantship.

• Faculty champions will continue to promote the value of SBIRT training for their program’s students and engage their fellow faculty to consider integrating all or part of the SBIRT curriculum into their courses.

• Faculty proficient in or with experience of teaching SBIRT should consider a role in training other faculty members.
Introduction

In the fall of 2013, the University of Alaska Anchorage (UAA) Center for Behavioral Health Research and Services (CBHRS) was awarded a three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to prepare Alaska’s workforce to provide early identification and intervention for substance misuse through the use of screening, brief intervention, and referral to treatment (SBIRT).

Working with the School of Nursing, the Department of Psychology, and the School of Social work at UAA, and the Alaska Family Medicine Residency, the project team set out to assist and support faculty in the training of their students in the SBIRT process and the integration of SAMHSA’s SBIRT curriculum into selected core courses within their programs.

Key Successes

Students reached and curriculum integration

Table 3 Number of students reached in each program in selected courses

<table>
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<td>Residency</td>
<td>33</td>
<td>Psychiatry rotation</td>
</tr>
</tbody>
</table>

Nine semesters (Spring 2014-Fall 2016)
Four target disciplines
709 individual student/residents trained
Over the course of the project, 709 students or residents were trained to use SBIRT. The majority of students reached at UAA were in one of three nursing programs, followed by social work and psychology students. Within the Alaska Family Medicine Residency, 33 residents were reached.

At UAA, the SBIRT curriculum was integrated into required courses in the AAS, BS, and MS nursing programs, the MS and PhD psychology programs, and into elective courses in the BSW and MSW social work programs, as well as sections of practice-based courses in both the BSW and MSW programs.

At the Alaska Family Medicine Residency, SBIRT training was integrated into the psychiatry rotation for the Year 2 residents.

**Student Practice Experience in the College of Health Interprofessional Simulation Center**

Students consistently identified skills-based practice opportunities such as role plays and case study simulations in the Simulation Center as key to increasing their knowledge and confidence in using SBIRT. Arctic SBIRT Training worked closely with the Simulation Center and faculty to provide students with opportunities to practice with standardized patients in a safe and supported setting. Scenarios were developed that focused on the Alaskan context and the types of situations that students might encounter in their practice. Faculty incorporated these simulations into their courses in a variety of ways, using various types of feedback and reflection exercises to reinforce learning.

**Curriculum Infusion Package**

A Curriculum Infusion Package (CIP) consisting of PowerPoints, reading materials, videos, a quiz bank, and other resources was developed to assist faculty in the use and integration of SAMHSA’s SBIRT curriculum into their courses. There are three modules in the curriculum, each designed to accommodate various class period lengths and learning modalities. This package has been made available via UAA’s course management and e-learning platform, Blackboard, as well as Google Drive and Office 365.

Related to the CIP is the *SBIRT Roadmap for Faculty*. This Excel document has a tab for each of the original SAMHSA SBIRT modules and their learning objectives, associated materials that could be provided to students to meet those learning objectives, and links to where to find those materials. This document was used to create the CIP but can be used on its own by faculty who are more familiar with SBIRT and wish to use SBIRT learning materials outside of the CIP to create a customized SBIRT class.

**Skills Demonstration Videos**

We worked with UAA’s Academic Innovations and eLearning and the Simulation Center to create seven skills demonstration videos. Nursing, psychology, and social work each had two videos demonstrating skills and context specific to that profession. The seventh video was interdisciplinary, demonstrating each profession’s potential role in the SBIRT process from screening to brief intervention to receiving a referral for treatment. These videos are available on the Arctic SBIRT Training YouTube channel ([www.youtube.com/channel/UCKLAaQFCj4aSgpRDX-Nheqq](http://www.youtube.com/channel/UCKLAaQFCj4aSgpRDX-Nheqq)).
Student Knowledge of SBIRT
All disciplines demonstrated a significant increase in knowledge. Medical residents had the highest levels of knowledge before SBIRT training but also experienced the greatest increase after SBIRT training. Nursing students demonstrated the smallest increase in knowledge after training.

![Figure 5 Student knowledge of SBIRT made significant increases](image)

Student Confidence to Use SBIRT
Trainees in all disciplines demonstrated a large and significant increase in confidence to use SBIRT skills for both alcohol and drugs. Medical residents had the lowest levels of confidence before SBIRT training but experienced the greatest increases after SBIRT training.

![Figure 6 Student confidence to use SBIRT made significant increases](image)

Student Perception of Responsibility to Use SBIRT in Their Practice
Small and in some cases non-significant changes in perceived responsibility to use SBIRT for alcohol and drugs were found across disciplines. Trainees endorsed high levels of responsibility to use SBIRT at baseline which left little room for improvement.
Student Satisfaction with SBIRT Training
Trainees indicated reasonably high levels of satisfaction with SBIRT training.

Technical Assistance Provided to Medical Clinics
Over the course of the grant, project staff also provided technical assistance in the form of training to several clinics as they implemented SBIRT into their wider clinic systems. The training consisted of a 2-3 hour practice-based workshop using SAMHSA’s SBIRT curriculum, and usually focused on screening for alcohol. Emphasis was placed on skills-based practice using a standard screening tool (the AUDIT or AUDIT US), brief intervention, and referral to treatment. A total of 11 such trainings were held over the course of the project, with a total of 170 (non-unique) participants.

Stakeholder Engagement and Outreach
Our Council of Directors (CoD) consisted of representatives from the participating disciplines, the State of Alaska Division of Behavioral Health, and health delivery systems. Throughout the project we endeavored to keep our Council of Directors engaged and informed about our work and progress through quarterly newsletters, frequent teleconference calls or in-person meetings. At least one in-person meeting was held in each year of the project, with emails and conferences calls convened in between.
Reflections and Future Considerations

Curriculum
The standard SAMHSA curriculum was developed in medical residency programs and not with the needs, structure, and time available in undergraduate and non-medical graduate programs. The original curriculum can take up to six hours to complete, if all activities and videos are used. Faculty reported feeling overwhelmed by the amount of material, that they were uncertain about what parts they needed to teach to maintain curriculum fidelity, and how to work it into already full course syllabi.

JBS International, SAMHSA’s technical assistance contractor, during a training site visit, was able to provide more information about the adaptations the fellow grantee made to meet the needs of other types of physicians, such as surgeons, and JBS confirmed that such adaptations could be made with fidelity to the original curriculum. With this in mind, we set about making our own substantial adaptations, which eventually became the Curriculum Infusion Package (CIP) and the SBIRT Roadmap for Faculty.

While the CIP is available in a variety of easily accessible locations (Blackboard, Google Drive, Office 365, and UA ScholarWorks), communicating its availability and utility to faculty new to SBIRT or UAA will likely remain a challenge post-funding. This was discussed during the Sustainability Site Visit in July, 2017. The project’s academic partners are discussing methods to ensure that this information is communicated when new faculty are assigned to target courses.

Online course access
At the outset of the grant, we were provided access to the online learning platform hosted for SAMHSA by JBS International via the Ideas Exchange. Access to this course was only available to grantees and their associates, through sending in names and email addresses to JBS staff. The majority of the project staff took this online course. The Alaska Family Medicine Residency program also utilized this course for the first 18 months of the project.

However, due to a lapse in the contract between SAMHSA and JBS International for the better part of nine months, access to the online course for new users was suspended in early 2015. This resulted in a search for a new online course for the family medicine residents, new faculty who were interested, and new staff coming on to the project.

A suitable course that matched the content was identified and information provided to the medical residency program. However, there were also periodic challenges with access to that course as well, as it changed hands in 2016. Concerns remain about the long-term sustainability of relying on outside entities for fundamental didactic training.

Faculty interest and engagement
At present, the long-term sustainability of SBIRT in program curricula is reliant on current faculty champions. However, engaging new faculty to become involved if they do not already have an interest in the topic has proven to be challenging. In addition, the freedom that faculty have in developing their course content means that unless they have an interest and value SBIRT as a prevention tool, they are unlikely to make the changes to their course syllabi needed to integrate SBIRT (even if the course guide includes SBIRT as a course requirement).
Upon receipt of the original SAMHSA curriculum, faculty feedback indicated they felt overwhelmed by the amount of material, uncertainty about what was key information and what could be safely left out yet still maintain fidelity to the curriculum, and how to work it into already full course syllabi. Faculty felt that in order to teach the material effectively, they needed training in not only SBIRT, but how to deliver the curriculum itself.

For this reason we submitted a technical assistance request to JBS International for this. JBS recruited a fellow grantee to assist one of their staff members with this workshop, which was held in August of 2014. In addition, the faculty workgroup suggested offering trainings with CEs attached to help address the faculty training issue. However, finding the ideal time of year, day, and time for faculty has been difficult, as over the summer most tenure-track faculty are off-contract and off-campus, but they are often too busy during the academic year to participate. Adjunct faculty provide additional challenges, as they are not tenure-track and must teach around their primary employment. While the trainings were offered on different days of the week and at different times (including a weekend), few faculty registered and none attended. Ongoing training post-funding will likely remain a challenge.

At the Sustainability Site Visit in July 2017, academic partner representatives discussed ways that they could influence faculty buy-in, from both a top-down and bottom-up approach. Faculty in the College of Health will arrange a meeting with the new dean; faculty in psychology will bring this topic to their colleagues in that department. They will also discuss how to best establish processes for introducing new faculty to SBIRT.

**Funding stability**

Some of the efforts undertaken through this project, such as the use of paid actors in the Simulation Center, will require an ongoing funding source beyond the funded period. The Alaska Medical Residency has already established this funding stream, and did so at the beginning of the project. Other programs are investigating or will institute a new laboratory fee for participation in a simulation experience. In addition, faculty in the College of Health will explore this topic with their new dean for collective use of the Simulation Center.

**Adoption of SBIRT**

The adoption of SBIRT into practice sites as a universal process is still in its early stages. This means that some graduating students who enter professional practice may not use their SBIRT skills, or be told that such screening and/or intervention activities are not in their normal scope of work. The ability – perceived or actual – to bill for SBIRT-related services further impacts its use in real world practice. This impacts whether faculty are willing to make room in their courses to teach skills that are not in demand by their students’ future employers.

To address this, efforts need to be made by the State of Alaska, the federal government, professional organizations, and other stakeholders to require SBIRT within healthcare delivery settings, given the strong evidence that it is an effective approach to reduce risky alcohol and substance use. In addition, SBIRT must be included in the accrediting standards of health professional training programs. Programs at UAA could offer SBIRT training to field and practicum placement sites or agencies in the future, and ensure that students are placed at sites that have already adopted SBIRT (or are in the process of doing so).
## Timeline of Milestones

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project start</strong></td>
<td><strong>Core Curriculum distributed</strong></td>
<td><strong>Technical Assistance Site Visit</strong></td>
</tr>
<tr>
<td><strong>First Council of Directors Meeting</strong></td>
<td><strong>Technical Assistance SBIRT Training</strong></td>
<td><strong>SBIRT Roadmap for Faculty drafted</strong></td>
</tr>
<tr>
<td>IRB approval for pre &amp; post surveys</td>
<td>Course integration - Fall</td>
<td>IRB approval for post-graduation survey &amp; faculty interviews</td>
</tr>
<tr>
<td>Pilot simulation experience in 3 classes</td>
<td><strong>Skills demonstration videos completed</strong></td>
<td><strong>Course integration - Spring</strong></td>
</tr>
<tr>
<td>Draft CIP modules deployed to Blackboard</td>
<td><strong>Distribution of draft CIP at grantees meeting - Baltimore</strong></td>
<td><strong>SBIRT webinar live on AK Nurses Assoc. website</strong></td>
</tr>
<tr>
<td><strong>Begin Mat-Su Health Clinics TA project</strong></td>
<td><strong>Course Integration - Fall</strong></td>
<td><strong>CIP finalized; videos live on YouTube</strong></td>
</tr>
<tr>
<td><strong>Course integration - Spring</strong></td>
<td><strong>Course Integration - Fall/Begin Closeout activities</strong></td>
<td></td>
</tr>
</tbody>
</table>
Implementation

Implementation of the proposed training and education efforts began in the fall of 2013 with the first meeting of the project’s Council of Directors (CoD) and receipt of SAMHSA’s SBIRT curriculum. The CoD provided useful early advice about potential facilitators and barriers to the project’s goals and objectives. Project staff reviewed the curriculum, made it available to faculty, and sought initial feedback on potential adaptations for the Alaskan context and learning settings. Plans were made to being the implementation into identified courses in the Spring 2014 semester. Please see below for information specific to the implementation of the SBIRT curriculum in each of the target disciplines.

Teaching SBIRT: SAMHSA’s Core Curriculum

The curriculum provided by SAMHSA is comprised of five “sessions” or modules.

- What is SBIRT and Why Use It?
- Screening
- Motivational Interviewing (which consists of three sub-modules)
- Brief Intervention: the Brief Negotiated Interview
- Referral to Treatment

Each of these modules had associated PowerPoint slide decks, faculty teaching guides and notes (as PDF files), module resources such as a role play scenario, literature reviews, and other materials broken out by session, a video that makes the case for SBIRT, and skills demonstration videos.

In the first 18 months of the project, the curriculum was available online through the Ideas Exchange Online Learning Management System. This site is supported by JBS International, s technical assistance contractor for SAMHSA.

Alaska Family Medicine Residency Program (AFMR)

Table 4 Number of family medicine residents reached and in which courses

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Program(s)</th>
<th>Residents reached</th>
<th>Courses with SBIRT content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>Residency</td>
<td>33</td>
<td>Psychiatry rotation</td>
</tr>
</tbody>
</table>

The original project plan called for training of all 36 residents each year. However, after reviewing the curriculum, and given the structure of the residency program, the Director of Behavioral Science at the AFMR determined that it would be more feasible to train the second-year residents as they went through their individual six-week psychiatry rotations. This reduced number of residents to be trained per year to a minimum of 12, with others trained as opportunities arose.

Each of these residents were initially required to complete SAMHSA’s online SBIRT training course offered through the Ideas Exchange, which included both didactic and skills demonstration learning content. Following the pause in the availability of this course in the spring of 2015 due to contractual issues between the host and SAMHSA, residents were directed to a similar, but publicly available course offered by the Southeastern Consortium for Substance Abuse Training (SECSAT www.sbirtonline.org/) that included the same content. Once they complete their online training, residents are required to participate in a simulation exercise with a standardized patient at the
Interprofessional Simulation Center. Residents complete two case scenarios during the simulation, observed by one of the AFMR’s behavioral scientists. Residents receive immediate feedback from the behavioral scientists through a joint review of the recorded patient interaction.

The AFMR has been able to secure a long-term funding stream to pay for the time in the Simulation Center and sees this as a permanently integrated part of the residents’ psychiatry training curriculum.

**Nursing**

*Table 5 Number of nursing students reached and in which courses*

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Total students reached</th>
<th>Programs</th>
<th>Courses with SBIRT content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>546</td>
<td>AAS</td>
<td>NS 250 Psychiatric Nursing (AAS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BS</td>
<td>NS 401 Health Disruptions II (BSN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MS</td>
<td>COHI 478/678 Interdisciplinary Explorations of Critical Behavioral Health Issues in AK</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NS 663 Family Nurse Practitioner IV (MS)</td>
</tr>
</tbody>
</table>

Following the receipt of the curriculum, the original courses in which SBIRT was to be implemented within the nursing programs were reviewed by and discussions held with the faculty who would be responsible for integrating the curriculum content into their courses. The faculty who had the most prior experience with SBIRT were the most engaged in this process and were the most willing to implement the needed changes to their course syllabus. This occurred in *NS A250 Psychiatric Nursing*, *NS A401 Health Disruptions II*, *NS A663 Family Nurse Practitioner IV*, and *NS 670 Advanced Psychiatric/Mental Health Nursing*.

It should be noted, however, that the integration of SBIRT in these courses was often dependent on who was teaching the course that semester (or in a couple of cases, which sections of the course they were teaching). It was observed that faculty who were less familiar with SBIRT were less likely to see the value of integrating the curriculum, or to suggest that the length of the original SAMHSA curriculum was not a good fit for their courses. Those faculty who did integrate SBIRT into their courses were either already familiar with it (via the small College of Health grant that was awarded to provide a small-scale interprofessional SBIRT simulation in the fall of 2013), or had an interest in substance use and addictions.

At present SBIRT appears best integrated in the graduate level courses in the FNP and Psych NP programs, which have also incorporated a voice-over PowerPoint that provides an overview of SBIRT as well as appropriate case studies for their Simulation Centers skills laboratory sessions. Certain sections of NS 250 have also integrated SBIRT, due to the interest and persistence of a particular faculty member. However, that faculty member does not explicitly use the SAMHSA curriculum.
### Psychology

*Table 6 Number of psychology students reached and in which courses*

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Total students reached</th>
<th>Programs</th>
<th>Courses with SBIRT content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology</td>
<td>103</td>
<td>MS</td>
<td>PSY 665 Psychotherapy Practicum (MS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PhD</td>
<td>PSY 682 Clinical Interventions for Substance Abuse (MS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COHI 678 Interdisciplinary Explorations of Critical Behavioral Health Issues in AK</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PSY 652 Practicum Placement I (PhD)</td>
</tr>
</tbody>
</table>

Following the receipt of the curriculum, the original courses in which SBIRT was to be implemented within the psychology graduate programs were reviewed by and discussions held with the faculty who would be responsible for integrating the curriculum content into their courses. Faculty who were also members of the Council of Directors played a key role and were significant champions in this process.

Initially, upon review of the curriculum, it was determined that it best fit in the *PSY A682-684 Clinical Interventions for Substance Abuse* course sequence, as well as *PSY A633 Tests and Treatment in Multicultural Context*. Due to unexpected changes in the faculty for the latter course at the beginning of the Spring 2014 semester, however, SBIRT was not integrated there. Further discussion after the end of that semester determined that SBIRT would remain primarily in *PSY A682-684*; efforts were shifted to the integration of SBIRT content and skills into the Psychological Services Center (PSC). The PSC provides a supervised environment in which students in the masters and PhD psychology programs can learn and practice their skills with patients.

The *PSY A682-684 Clinical Interventions for Substance Abuse* course sequence uses the curriculum’s PowerPoints, case studies, and other reading materials, as well as time in the Simulation Center with standardized patients.

In the PSC, students initially took the online course offered through SAMHSA’s Ideas’ Exchange online learning platform, as well as additional materials and resources made available through Blackboard. In the initial year of implementation in the clinic, SBIRT was discussed and demonstrative role plays provided to support the online learning. The full AUDIT was integrated into the clinic’s intake form, with the intent that alcohol use would be discussed and a brief intervention provided as appropriate. However, many individuals who indicated that they experience risky alcohol use behaviors are screened out of the PSC and referred to treatment programs, as they are considered to be too complex for students at this stage of their learning.

In the following academic year, competing priorities meant that clinic group discussions lapsed, at the same time as access to SAMHSA’s online course did. To address the latter, the initial version of the CIP was made available on Blackboard (PowerPoints, reading materials, etc.) for students to access themselves, with the intent that group discussions would resume. Despite this, feedback indicated that students did not feel comfortable providing the brief intervention nor understood when and how it was supposed to be done.

Further in person training was held with students in the clinic in the following academic year, which included a new faculty member who would eventually be taking over the role of the clinic director. According to feedback, this in-person training assisted students in understanding the SBIRT
framework, but supporting group discussions in the PSC, and follow-up with clients did not resume as hoped due to continued competing priorities. However, the new clinic director has a specific interest in addictions, so it is anticipated that they will place a renewed focus in this area.

**Social Work**

*Table 7 Number of social work students reached and in which courses*

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Total students reached</th>
<th>Programs</th>
<th>Courses with SBIRT content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>125</td>
<td>BSW MSW</td>
<td>SWK 440 Social Work Practice in Mental Health and Addictions (BSW)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SWK 459 Social Work Practicum II (BSW)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SWK 630 Practice Skills Lab (MSW)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SWK 633 Direct Practice II (MSW)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SWK 651 Social Work in Addictions and Mental Health (MSW)</td>
</tr>
</tbody>
</table>

At the outset of the grant, two courses were identified for potential SBIRT integration: *SWK 440 Social Work Practice in Mental Health and Addictions* at the undergraduate level and *SWK 651 Social Work in Addictions and Mental Health* at the master’s level. Unlike nursing and psychology, both of these courses are elective courses; no core courses in either the undergraduate or graduate level were identified as targets for implementation. Faculty for these courses are generally adjuncts (non-fulltime, tenured faculty), again unlike the target courses in the other disciplines. These classes are offered on an every-other-semester basis. The undergraduate course was offered only in-person, with Blackboard acting as a content management system for the class. The graduate level course was offered in both an online and in-person format at various points during the project; from Fall 2016, it will only be offered online.

*SWK 651 Social Work in Addictions and Mental Health* made use of the curriculum’s PowerPoints, case studies, and reading materials each time it was offered. In Spring 2015 the course was one that piloted the use of the Sim. Center for practice-based experience with standardized patients.

*SWK 440 Social Work Practice in Mental Health and Addictions* also made use of the curriculum’s PowerPoints and screening tool materials in one semester it was offered; the following semester under a different instructor, videos and articles were used.

Long-term integration of SBIRT into these courses is likely to be dependent on the interest of the adjunct faculty teaching it.

**Interprofessional Health Sciences Simulation Center**

The partnership with the Simulation Center was established at the very outset of the project. The Simulation Center provides health professional students and residents opportunities to practice their skills with standardized patients (in the case of SBIRT practice, usually paid actors) in a safe and secure setting. Students’ sessions in the center can be recorded for later reviewing by faculty and students for formal and peer feedback.

Modifications of existing case studies were made in the early months of the project to use in the Sim. Center so that they better reflected the Alaskan context and types of situations that students
might encounter in their professional practice. Additional case studies were also developed; there are now a total of six case studies per discipline for use in the Sim. Center or in-class role plays. Care was made to ensure that the cases were diverse and presented a range of drinking habits such as binge drinking, very heavy drinking, drinking during pregnancy, potentially dependent, and previously dependent. These cases are essentially the same across disciplines, with details modified to reflect the types of skills and activities that each profession would need in their day-to-day practice.

One of the challenges expressed by faculty early on was how to best fit role-play or simulation activities into limited class time. After discussions with the Sim. Center team and faculty, it was determined that it would be best to have students schedule time outside of class to practice their skills with actors (standardized patients). This was piloted with graduate classes in psychology and social work in the Spring 2015 semester as those classes were smaller, but it was later broadened to include nursing undergraduate and graduate courses. Depending on the class, students would interact with a patient or client (an actor), practice the SBIRT protocol with them while being recorded, and then either receive feedback immediately from a faculty member or student peer or both, or the faculty member would review the recording and provide feedback at later date. One class required students to write a reflective paper on the experience.

**Interprofessional Simulation Activities.** At the beginning of the project, a concurrent effort was underway to conduct an interprofessional SBIRT simulation activity between several disciplines within the College of Health (nursing, social work, dietetics). This was funded by an internal grant from the College of Health and was coordinated by that college’s Interprofessional Simulation Committee. Several of the faculty who were involved in that project became key faculty for the integration of the SBIRT curriculum during the Arctic SBIRT Training project period. The project provided technical assistance support for another effort by this committee to hold a semester-long Interprofessional simulation using the same case studies across disciplines including graduate nursing, social work, psychology, and the medical laboratory technician programs.

**Blackboard**
At the outset of the project, with the assistance of staff at the School of Nursing, a course ‘shell’ was established in UAA’s web-based learning platform, Blackboard. This shell was set up to house the curriculum materials and other associated documents and resources. Access to this shell was provided to any faculty member who teaching SBIRT, as well as staff and students associated with the project. Blackboard provided a mechanism through which faculty could easily copy materials from the SBIRT shell to their own courses. This shell was frequently updated with new materials or updated curriculum resources and is intended to remain available beyond the funding period.

**Stakeholder Engagement**
To provide advice and guidance, a Council of Directors (CoD) was convened in the first months of the grant, consisting of community stakeholders such as the State of Alaska Division of Behavioral Health, faculty from the target disciplines, and a national consultant and fellow SBIRT grantee from the University of California San Francisco. Please see Appendix 3 for a complete list of CoD members. Throughout the project we endeavored to keep our CoD engaged and informed about our work and progress through quarterly newsletters (which were also posted on the project website), frequent teleconference calls or in-person meetings.

**Project website.** In the early months of the grant, we established a project website at [www.uaa.alaska.edu/research/institute-social-economic-research/sbirt](http://www.uaa.alaska.edu/research/institute-social-economic-research/sbirt). Here we included a short
Arctic SBIRT Training Final Report

Blurb on what SBIRT is, the goals of the project, information on SAMHSA’s curriculum, our partners, and other resources. We also uploaded our quarterly newsletters to the site, and included a link for the public to join our mailing list.

**Newsletters.** Beginning the Fall of 2014 we produced a roughly quarterly newsletter detailing activities in the previous months, a snapshot of evaluation data, a calendar for the coming months, and updates from the participating disciplines. These were distributed to the CoD, other interested stakeholders, and uploaded to the project website.

**Faculty Workgroup.** In addition to the CoD, a smaller subgroup of faculty (from psychology, social work, nursing, and the Simulation Center) met in 2016 to discuss issues related to sustainability and the CIP. Maintaining SBIRT in courses beyond the grant was a key part of these discussions. Challenges to this include the level of academic freedom that faculty have in designing their courses. While there is a course guide for each course taught at UAA, these are deliberately broad; two faculty members teaching different sections of the same course may have significantly different content. This means that even if SBIRT was to be included in the guide, how it’s taught would be up to the discretion of the instructor. Another challenge is to gain the buy-in of new faculty (to UAA and/or to SBIRT). Suggestions from the workgroup included offering CEs connected to training sessions, offer workshops at discipline-specific conferences, using SBIRT as skills-based practice the Simulation Center, and offering faculty online SBIRT courses for CE credit.

**Dissemination activities.** Over the course of the project we made presentations (lectures, panels and posters) about our work and SBIRT more broadly at several conferences. These included the Alaska Public Health Summit (2015 and 2016), the Alaska Nurses Association annual conference (2015 and 2016), the International Conference on the Teaching of Psychology (2015) the Alaska Maternal Child Health and Immunization Conference (2016), the 2016 grantee meeting, the Western Psychological Association (2017), and the Society of Behavioral Medicine (2017). In addition, manuscripts have been drafted and have been or will be submitted for peer-reviewed publication in 2017.

**Other outreach.** At various points over the course of the project we participated in outreach events such as Campus Kickoff and the UAA health fair, and panel and poster presentations at local conferences.

**Sustainability**
Sustainability of our efforts post-award has been a guiding focus of the project from its inception. This has contributed to the development of resources such as the CIP and the *SBIRT Roadmap for Faculty*, as they can live on and be used after funded support for the work has ended. Discussions were held early in Year 4 with the library and ScholarWorks to establish a home for the CIP and associated materials, as recommended by the CoD.

At the Simulation Center, thought has been given regarding how to maintain access to paid actors so that students can continue to have simulation experiences. Laboratory fees are being considered for psychology, social work, and nursing. The Alaska Family Medicine Residency established a funding stream through the WWAMI program early in the project to sustain their access to paid actors.

Maintaining trained faculty is a significant challenge to long-term sustainability. At the end of the project, SBIRT’s continued inclusion in the target courses is essentially reliant on the faculty champions now teaching those courses. Discussion with faculty have indicated that there is no organized way for departments to train incoming faculty, and as noted previously, faculty have the
freedom to develop their course syllabi as they wish as long as they follow the broadly developed course guides. This means that expanding buy-in from faculty not involved with the project is key to its long-term success. This may need to be done by the faculty champions and through the encouragement of engaged departmental administrators. Please see Reflections and Future Considerations for more discussion on this.

**Technical Assistance**

**Site Visit.** In April, 2014 the project received its first technical assistance/site visit from SAMHSA and its technical assistance contractor, JBS International. This site visit provided the project staff with the opportunity to receive consultation from JBS staff and a fellow grantee with experience in implementing the curriculum into courses in an academic (non-medical school) setting, discuss potential barriers and opportunities for overcoming them, and other possible technical assistance needs. During the course of this meeting it was determined that further faculty and staff training to use and deliver SAMHSA’s SBIRT curriculum in a classroom setting would be beneficial. Arrangements were made for this training to occur in August, 2014. It was provided by an expert from JBS International and a fellow grantee. Project staff, faculty, and other UAA staff participated in this practical, skills-based workshop.

**Training Assistance.** The project also provided technical assistance in the form or training to three clinics in the Mat-Su Valley (Sunshine Community Health Center, Solstice Family Clinic, and Mat-Su Health Services) and to Providence Family Medicine Clinic. The training consisted of a 2-3 hour practice-based workshop using the SBIRT curriculum. Emphasis was placed on skills-based practice using a standard screening tool (the AUDIT or AUDIT US), brief intervention, and referral to treatment. A total of 11 such trainings were held over the course of the project, with a total of 170 participants. Since some sites received multiple trainings (an initial workshop and then a refresher), this is not a unique count of participants.

*Table 8 Number of professionals trained*

<table>
<thead>
<tr>
<th>Trainee type</th>
<th>Number trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>15</td>
</tr>
<tr>
<td>Nurses</td>
<td>34</td>
</tr>
<tr>
<td>Medical/Physicians’ Assistant</td>
<td>35</td>
</tr>
<tr>
<td>Psychology/Behavioral Health</td>
<td>21</td>
</tr>
<tr>
<td>Social Work</td>
<td>14</td>
</tr>
<tr>
<td>Administrator</td>
<td>26</td>
</tr>
<tr>
<td>Care Manager</td>
<td>4</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
</tr>
<tr>
<td>Dental Assistant</td>
<td>2</td>
</tr>
<tr>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Patient Advocate</td>
<td>4</td>
</tr>
<tr>
<td>Behavioral/Social Science Health Researcher</td>
<td>8</td>
</tr>
</tbody>
</table>
Satisfaction with these trainings was generally high, but as this was not the primary focus of the project, detailed analyses of post-training surveys was not conducted.

**Sustainability site visit.** In the last quarter of the project, JBS International facilitated a site visit to focus on an action plan for sustaining project efforts after the funding period has ended. This visit was combined with the final Council of Directors meeting in July, 2017. In attendance were project staff, psychology faculty, nursing faculty, social work faculty, Simulation Center staff, and Family Medicine Residency staff.

The goals of the site visit included:

- The establishment of a program vision post-SAMHSA funding.
- The assessment the existing capacity for sustainability.
- The development of action steps around eight key domains for sustaining SBIRT services (based on the PSAT): environmental support, funding stability, communications, strategic planning, partnerships, program service design, program evaluation, and organizational capacity.

The meeting included a brief review of the project’s accomplishments (products developed, preliminary final evaluation findings, etc.) as well as in-depth discussion about the facilitators and barriers to continuing the project’s work post-grant.

Following the meeting JBS International provided the project and SAMHSA a Site Visit Report detailing the proposed action steps discussed at the site visit.
Materials and Tools Developed

Curriculum Infusion Package
The Spring, 2014 semester was the first in which faculty had an opportunity to use the curriculum in a classroom situation. This curriculum was designed and developed with medical residents in mind; using it as provided would have required faculty to set aside approximately four to six hours of class time. It was immediately clear that it would have to be significantly modified to fit a semester-based learning environment.

A matrix was developed for use by faculty to help them navigate the curriculum, under the assumption that faculty would be best placed to know how much and what to incorporate depending on their time constraints. This matrix was created in Microsoft Excel and has tabs for each of the five modules in SAMHSA’s original curriculum, their learning objectives, the slides in the curriculum that address those objectives, resources available for each module and how to access those (using hyperlinks were available). This spreadsheet eventually became the SBIRT Roadmap for Faculty (see below).

However, in feedback received at the end of the Spring 2014 semester, faculty indicated they felt overwhelmed by the amount of materials that they could use and that they did not have time to wade through it, especially if they were not that familiar with SBIRT. With this in mind the next modification made was to the length of the curriculum.

Project staff reviewed the entire curriculum, condensing the PowerPoint slide decks, activities, and videos into three modules so that a presentation could be delivered within one of three timeframes: 60 minutes, 90 minutes, and 120 minutes. These modules are “stackable”; that is, they build on each other by adding activities and videos to the initial PowerPoint slide deck to expand learning modalities. To supplement the in-class learning, and under the assumption that all students will be assigned pre-class readings, peer reviewed and grey literature are provided as recommended background reading. They can also be paired with practice in the Simulation Center outside of class time. Finally, a bank of quiz, exam, or assignment questions is also provided as part of the CIP. These are provided in a Word document so that faculty can pick and choose which to include. An answer key is also included.

The CIP has been uploaded to Blackboard, to Google Drive, and to Office 365.

SBIRT Roadmap for Faculty
The SBIRT Roadmap for Faculty is an Excel spreadsheet comprised of five tabs, one for each of the original SAMHSA modules. Each tab has a list of the original learning objectives for that module, which original and CIP slides address that learning objective, and various materials and resources that also address those objectives. These include peer reviewed literature, grey literature, and videos.

This roadmap can be used by faculty who are more familiar or comfortable with teaching SBIRT or with the SAMHSA curriculum to put together their own training materials that address the core objectives of the SBIRT curriculum to meet their course’s goals and class time frames.

Case Studies
One of the first modifications the SBIRT team made was to the case studies provided with the curriculum. Using those as a guide, other case studies were developed that better represented the types of clients/patients or situations health care providers in Alaska were likely to see. A minimum
of six such case studies were developed and tested by faculty in their classrooms or in the Simulation Center, and adjustments subsequently made where necessary. See Appendix 2 for a list of these case studies.

**SBIRT Student Algorithm**
While there are several pocket guides for SBIRT protocols available, none were developed with the learning needs of students, who generally have fewer practice-based skills or experience. With this in mind, we developed a one-page color-coded guide, the *SBIRT Student Algorithm*, that includes a reminder to develop a relationship first (introductions, raising the subject), followed by a section on how to conduct screening, then the brief intervention, then referral to treatment. On the flip side of the guide is a copy of the AUDIT US screening tool, standard drink size guide, a readiness ruler, and an alcohol use pyramid, all key parts of the SBIRT curriculum used to engage a patient or client in discussion. This tool was then made available to students in their classes and in the Sim. Center, and incorporated into the CIP.

**Skills Demonstration Videos**
In response to faculty feedback that the available videos did not adequately demonstrate the situations, SBIRT-related skills, or Alaskan context that their students would need or encounter in their professional lives, we worked with UAA’s Academic Innovations and eLearning and the Simulation Center to create seven skills demonstration videos. Nursing, psychology, and social work each had two videos demonstrating skills and context specific to that profession. The seventh video was interdisciplinary, demonstrating each profession’s potential role in the SBIRT process from screening to brief intervention to receiving a referral for treatment. Actors were recruited by the Simulation Center to play the patients, and faculty members from each discipline demonstrated the skills from their professional perspective.

These videos are available on the Arctic SBIRT Training YouTube channel ([www.youtube.com/channel/UCKLAaQFCi4aSqpRDX-Nheqg](http://www.youtube.com/channel/UCKLAaQFCi4aSqpRDX-Nheqg)).
Outcome Evaluation

Evaluation Design and Methods
A repeated measures outcome evaluation design was used by the Arctic SBIRT team to study change in student SBIRT knowledge, attitudes, and behaviors before and after delivery of SBIRT curriculum into psychology, social work, nursing, and family medicine residency programs. Students completed measures before and after SBIRT training and one year following graduation. Informed consent was obtained and consenting students completed pre and post training surveys either in-person or online, depending on available class time and structure. To explore SBIRT usage following graduation, consenting trainees were contacted one year after graduation via email to complete an online post-graduation survey. Individuals who participated in the post-graduation survey were compensated with a $20 Starbucks gift card. Students did not receive compensation for pre or post survey participation as they were completed as part of regular classroom activities.

Survey Measures
All survey measures are included in Appendix 4.

Knowledge, Attitudes and Behavior (KAB) Survey. Nineteen knowledge questions were created by the Arctic SBIRT team which were derived from the learning objectives of the original SBIRT curriculum. Questions included topics such as risky substance use behaviors, alcohol risk limits, and skills related to motivational interviewing and the brief intervention. Each knowledge question is scored as one point and summed to generate a total knowledge score out of 19. Higher scores indicate greater knowledge. Twelve questions, six pertaining to alcohol and six pertaining to drugs, were created to assess students’ perceived responsibility as healthcare professionals to implement and execute SBIRT. Students rated items on a 5-point Likert scale with 1 indicating “no responsibility” and 5 indicating “major responsibility”. Mean scores were generated across items with high scores representing high responsibility to execute SBIRT. Twelve questions, six pertaining to alcohol and six pertaining to drug use, were created to assess students’ confidence in executing elements of SBIRT. Examples of questions included “how confident are you in your ability to use a standardized screener to assess alcohol/drug use?” Items were rated on a 5-point Likert scale with 1 representing “no confidence” and 5 representing “high confidence. Mean scores were generated across items with high scores representing high confidence to conduct SBIRT tasks.

SAMHSA Training Satisfaction Survey. The training satisfaction survey is a requirement of SAMHSA and comprised of 16 questions about aspects of trainee satisfaction with SBIRT training received. Using a scale of 1 “very dissatisfied” to 5 “very satisfied” trainees rated statements such as organization of the training, instructor knowledge and responsibility, perceived value of the training,
and expectations to use SBIRT. Items are summed to create an overall satisfaction score with higher scores indicating higher satisfaction. One question examined usefulness, asking participants to rate the training from 1 “very useful” to 4 “useless” and five questions gathered demographic information such as gender and race. Finally, two questions provided the opportunity for open-ended responses on the usefulness of SBIRT for work responsibilities and how the SBIRT training could be improved.

Post-Graduation Survey. Ten items gathered information about current employment or student status, use of SBIRT at the current place of employment, perceived effectiveness and usefulness of SBIRT, and any other use of SBIRT outside of employment or internship after graduation. One open-ended question assessed the usefulness of SBIRT when working with clients or patients. Additionally, post-graduation survey participants completed the confidence and responsibility subscales of the KAB survey described above.

Reach of SBIRT Training and Survey Response Rates
Over the span of nine academic semesters, a total of 810 (546 nursing, 125 social work, 103 psychology, 33 medical residents) trainees were provided SBIRT Training. These counts include students who received SBIRT more than once, which was most common in psychology and social work disciplines. It is estimated that approximately 100% of Medical Residents, 70% of nursing students, 55% of social work students and 80% of psychology students enrolled in their respective disciplines received SBIRT training during the Arctic SBIRT grant.

The Arctic SBIRT team encountered some barriers in maintaining high survey response rates over the duration of implementation. Both difficulty reaching faculty and time constraints during classes resulted in greater reliance on online versus in-person pre and post survey delivery methods which
was found to yield lower response rates. Response rates by discipline are provided below and reflect all surveys received.

Results
Pre and Post Survey. Pre- to post-training change in student SBIRT knowledge, confidence and responsibility to use SBIRT was analyzed using a 4 × 2 Discipline (MR, PSY, SW, NUR) by Time (pre, post SBIRT training) repeated-measures multivariate analysis of variance with SBIRT knowledge, confidence to use SBIRT for alcohol, confidence to use SBIRT for drugs, responsibility to use SBIRT for alcohol, and responsibility to use SBIRT for drugs as dependent measures. Results indicated significant main effects for Discipline, $F(15, 842) = 3.76$, $p < .01$; Wilk’s $\Lambda = .836$, $\eta^2 = 0.058$; Time, $F(5, 305) = 55.03$, $p < .01$; Wilk’s $\Lambda = 0.526$, $\eta^2 = 0.474$; and Discipline × Time interaction, $F(15, 842) = 2.84$, $p < .01$, Wilk’s $\Lambda = 0.873$, $\eta^2 = 0.044$.

Discipline Main Effect. Follow-up univariate tests revealed significant differences in the overall means for SBIRT knowledge but not for confidence to use SBIRT for alcohol, confidence to use SBIRT for drugs, responsibility to use SBIRT for alcohol, and responsibility to use SBIRT for drugs when disciplines were compared to each other. In reference to knowledge, medical residents had significantly higher mean knowledge scores ($M = 13.3$) than nursing ($M = 9.8$), psychology ($M = 11.0$), and social work ($M = 9.7$) students as revealed by pairwise comparisons. Psychology students also had significantly higher mean knowledge scores than nursing and social work students.

Time Main Effect. Follow-up univariate tests showed a significant difference in the overall means across all dependent measures including SBIRT knowledge ($M_1 = 9.8$, $M_2 = 12.1$) confidence to use SBIRT for alcohol ($M_1 = 3.4$, $M_2 = 4.4$), confidence to use SBIRT for drugs ($M_1 = 3.4$, $M_2 = 4.4$), responsibility to use SBIRT for alcohol ($M_1 = 4.4$, $M_2 = 4.6$), and responsibility to use SBIRT for drugs ($M_1 = 4.5$, $M_2 = 4.7$).

Discipline × Time Interaction Effect. Follow-up univariate tests for Discipline by Time interaction (see Table 2) identified significant increases in means for SBIRT knowledge, confidence to use SBIRT for alcohol, and confidence to use SBIRT for drugs across all disciplines. Small, and in some cases, non-significant increases in perceived responsibility to use SBIRT for alcohol and drugs were found across disciplines due to already high scores at baseline, providing little room for improvement. Medical residents experienced the largest gains on all outcome measures based on univariate effect sizes.

Table 9 Results of pre to post survey change in SBIRT knowledge, confidence, and responsibility by discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Pre</th>
<th>Post</th>
<th>$F$</th>
<th>$\eta^2$</th>
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<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
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<tr>
<td>Knowledge</td>
<td>11.69</td>
<td>2.43</td>
<td>15.00</td>
<td>2.00</td>
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<tr>
<td>Confidence Alcohol</td>
<td>3.29</td>
<td>.56</td>
<td>4.50</td>
<td>.54</td>
</tr>
<tr>
<td>Drugs</td>
<td>3.15</td>
<td>.63</td>
<td>4.50</td>
<td>.54</td>
</tr>
<tr>
<td>Responsibility Alcohol</td>
<td>4.63</td>
<td>.40</td>
<td>4.91</td>
<td>.16</td>
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<tr>
<td>Drugs</td>
<td>4.71</td>
<td>.34</td>
<td>4.93</td>
<td>.16</td>
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<tr>
<td>Nursing ($n=210$)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>9.03</td>
<td>2.39</td>
<td>10.52</td>
<td>2.61</td>
</tr>
<tr>
<td>Confidence Alcohol</td>
<td>3.63</td>
<td>.82</td>
<td>4.20</td>
<td>.66</td>
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<tr>
<td>Drugs</td>
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<td>Responsibility Alcohol</td>
<td>4.42</td>
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Social Work ($n=52$)

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<tr>
<td>Alcohol</td>
<td>3.31</td>
<td>1.03</td>
<td>4.23</td>
</tr>
<tr>
<td>Drugs</td>
<td>3.27</td>
<td>1.04</td>
<td>4.21</td>
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<tr>
<td>Alcohol</td>
<td>4.22</td>
<td>.89</td>
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<tr>
<td>Drugs</td>
<td>4.31</td>
<td>.86</td>
<td>4.49</td>
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Psychology ($n=38$)

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<th>Confidence</th>
<th>Responsibility</th>
</tr>
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<tr>
<td>Alcohol</td>
<td>3.57</td>
<td>.77</td>
<td>4.48</td>
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<tr>
<td>Drugs</td>
<td>3.50</td>
<td>.73</td>
<td>4.52</td>
</tr>
<tr>
<td>Alcohol</td>
<td>4.43</td>
<td>.43</td>
<td>4.57</td>
</tr>
<tr>
<td>Drugs</td>
<td>4.44</td>
<td>.38</td>
<td>4.61</td>
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Training Satisfaction. Trainees indicated reasonably high levels of satisfaction with SBIRT training. As part of the SAMHSA training satisfaction survey, trainees were asked to provide suggestions for improvement. Regardless of discipline, suggested improvements focused on increases in the duration of SBIRT training and more opportunities to practice SBIRT skills. Students expressed a desire for in-person training from professors rather than online or self-taught modalities. Student trainees indicated that they would feel more competent with greater exposure to the SBIRT curriculum, role plays, and simulation experiences.

Use of SBIRT after graduation. The post-graduation survey was completed by a small number of graduates from social work ($n=17$) and nursing ($n=44$) disciplines. Use of SBIRT as standard practice after graduation is not common based on post-graduation survey results. Among social work graduates employed in their field, 41.7% reported that SBIRT is encouraged or available for use at their place of employment but none reported use of SBIRT as standard practice. Among nursing graduates employed in their field, 27.6% reported that SBIRT is encouraged or available and 25.0% reported use of SBIRT as standard practice.
SBIRT Use after Graduation Among Social Work Trainees (n = 17)

- **70.6% - Employed in Degree Field (n=12)**
  - In Alaska, 73.3%
  - Jobs: Social Worker, Mental Health Specialist

- **% - Employed in Other Field, Unemployed, Still in School (n=5)**

Is SBIRT promoted at your place of employment?

- **41.7% - Yes (n=5)**
  - SBIRT is standard practice, 0.0%
  - SBIRT is encouraged or available, 100.0%
  - SBIRT training received on-the-job, 20.0%
  - Employers: CITC, VOA, National Guard, other

- **58.3% - No (n=7)**
  - No talk of future use, 100.0%
  - SBIRT training received on-the-job, 0.0%
  - Employers: Various others

Do you provide SBIRT to your patients?

- **80.0% - Yes (n=4)**
- **20.0% - No (n=1)**

Is another universal screening/intervention used? (Only if SBIRT is NOT standard practice)

- **66.7% - Yes (n=8)**
  - Examples: CRAFFT/AUDIT, CSR, ACT, few others

- **33.3% - No (n=4)**

How effective is SBIRT for your patients?

- **25.0% - Mostly or Extremely (n=1)**
- **75.0% - A Little or Somewhat (n=3)**

Other ways that SBIRT is used other than through a current job or internship

- Examples: No examples provided

Comments about SBIRT and its usefulness in your current position

- “SBIRT is helpful in military and civilian medical settings – assessing needs for soldiers, determining readiness for change, and referrals”
- “As a mental health clinician, it is useful as a brief intervention for alcohol or drug prevention”
- “It is good for crisis intervention related to substance use.”

Figure 12: SBIRT use after graduation among social work graduates
SBIRT Use after Graduation Among Nursing Trainees (n = 44)

86.4% - Employed in Degree Field (n=38)
In Alaska, 84.2%
Primary job titles: RN or Nurse practitioner

13.6% - Employed in Other Field or Unemployed (n=6)

Is SBIRT promoted at your place of employment?

52.6% - Yes (n=20)
- SBIRT is standard practice, 25.0%
- SBIRT is encouraged or available, 75.0%
- SBIRT training received on-the-job, 20.0%
Employers: Providence Alaska, ANMC, other

47.4% - No (n=18)
- No talk of future use, 100.0%
- SBIRT training received on-the-job, 0.0%
Employers: Fairbanks Memorial, many others

Do you provide SBIRT to your patients?

40.5% - Yes (n=8) 59.5% - No (n=12)

Is another universal screening/intervention used? (If SBIRT is NOT standard practice)

69.7% - Yes (n=23)
Examples: Screening questions (Epic), CAGE

30.3% - No (n=10)

How effective is SBIRT for your patients?

25.0% - Mostly or Extremely (n=3)
75.0% - A Little or Somewhat (n=9)

Other ways that SBIRT is used other than through a current job or internship

Examples: Intervention with friends and helping family find treatment options

Comments about SBIRT and its usefulness in your current position

“I use brief interventions—particularly the education component with all my patients who use ETOH in excess or who smoke cigarettes. Referrals happen, but less than the brief interventions because patients don’t often express desire for referral, or they refuse referral outright. So the RN and I just keep screening, and I keep doing the brief interventions, hoping that eventually a patient will accept a referral.”

“SBIRT is a good tool, although the biggest barrier I find is the patient’s readiness to listen. Depending on that I may include a referral and let them know what’s available when they’re ready.”

“It’s useful as a brief intervention for those who don’t fully comprehend their use of alcohol may be excessive and/or unhealthy. Many in my region blow it off, or are already seeking treatment of some kind, so an official referral is very rarely made.”

Figure 13 SBIRT use after graduation among nursing graduates
Confidence and perceived responsibility to use SBIRT after graduation. Pre-training, post-training, and post-graduation change in confidence and responsibility to use SBIRT among social work and nursing graduates who completed the post-graduation survey was analyzed using a repeated-measures MANOVA (see Figure 1). A significant multivariate effect of time on confidence and responsibility to use SBIRT for alcohol and drugs was found, $F(8,148) = 8.37$, $p < .001$; Wilk’s $\Lambda = 0.457$, partial $\eta^2 = .324$. Pairwise comparisons identified significant increases in confidence to use SBIRT for drugs and alcohol at both post-training and post-graduation, compared with pre-training levels. However, significant decreases in perceived responsibility to use SBIRT for drugs and alcohol were found at post-graduation, compared to both pre-training and post-training levels. Decreases in perceived responsibility after graduation aligns with the low levels of SBIRT use in places of employment after graduation. If SBIRT is not being used in practice, it seems reasonable that graduates may no longer feel SBIRT is part of their professional duties after graduation.

Confidence to use SBIRT ($n = 39$)

Responsibility to use SBIRT ($n = 39$)

*Figure 14* Pre, post, and post-graduation confidence and responsibility to use SBIRT
Appendices

Appendix 1: Rationale for the Arctic SBIRT Training Project

Substance abuse, including the misuse of alcohol, tobacco, or the use of illegal or prescription drugs for non-medical reasons, is the number one health concern in Alaska (Hull-Jilly & Casto, 2013). In 2013, Center for Behavioral Health Research and Services (CBHRS) received a three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a systematic, ongoing training and workforce development project to address substance use and abuse: Arctic SBIRT Training. The primary goal of the project was to prepare Alaska’s healthcare professions to provide early identification and intervention for substance misuse through training and practice in screening, brief intervention, and referral to treatment (SBIRT), thereby reducing the health consequences of substance misuse.

SBIRT is a process of identifying individuals who may be using alcohol, illegal, or prescription drugs in ways that are potentially harmful. It is a public health model that focuses on early intervention and prevention. The Arctic SBIRT Training project focused its efforts on adapting the SBIRT curriculum distributed by SAMHSA for use by faculty in the nursing, social work, and psychology programs at the University of Alaska Anchorage, and the Alaska Family Medicine Residency program.

Alcohol. Alcohol misuse plays a primary role in unintentional injury; it is the third leading cause of death in Alaska. In addition, high rates of unintended pregnancies combined with high rates of drinking among younger women are significant contributors to Alaska’s high rate of FASDs, which is another pressing health concern and a contributor of health disparities.

Drugs. The use or misuse of drugs, including the use of prescriptions for non-medical reasons, is a co-contributor to the leading causes of death and injury. Over 10% of all hospitalized injury patients in Alaska had suspected or proven drug use1. Also of serious concern, Alaskans commit suicide at nearly twice the U.S. rate3. More than 90% of people who commit suicide have a diagnosable, treatable mental and/or substance use disorder4.

Economic Impact. The costs associated with substance abuse affect fundamental aspects of life including work, family, and safety. In 2010, the costs of substance abuse to Alaska’s economy totaled $1.2 billion. In addition to $237.3 million spent in the healthcare sector, alcohol and drug abuse resulted in $673.2 million in lost productivity, $217.7 million in criminal justice and protective services including child protective services, and $50.5 million in injury and property damage related to traffic accidents6.

Systems and policy change. The U.S. Preventive Services Task Force recommends that all adult patients in a primary care setting be screened for alcohol and drug misuse and provided counseling for identified risky or harmful drinking and substance abuse8,9. Studies implementing routine screening and early intervention for substance use disorders in healthcare settings have shown a net reduction in alcohol consumption ranging from 12 to 38%10,11, substance use improvements of up to 68%12, and cost savings from both a health system perspective and a societal perspective13,14. In addition, research has indicated that patients are receptive and ready to listen to advice from their provider related to their drinking and substance use15. Yet routine screening using standardized assessments, evidence-based interventions, treatment or referral are extremely underutilized in healthcare settings, both for the general population16,17, and even for women of reproductive age18.
Alaska relies on its own infrastructure to address the health concerns of its culturally diverse population, and needs health care professionals trained to work in its unique environments and systems of care. Given Alaska’s workforce shortages and geographically dispersed population, many patients are still routinely seen by non-physician providers including nurses, social workers, and community health aides. Thus, implementing routine screening and brief intervention in Alaskan health care facilities must be multidisciplinary to assure that patients receive preventive services and treatment regardless of where they live, or their provider’s discipline.

**Project Goals**

Arctic SBIRT Training’s overarching goal was to prepare Alaska’s workforce to provide early identification and intervention for substance misuse through SBIRT training, thereby reducing the health consequences of substance abuse and improving the health of Alaska’s population.

To accomplish this goal, six specific objectives were developed to facilitate the institutionalization and spread of SBIRT among healthcare trainees and practice settings:

1. Adapt and implement SAMHSA’s SBIRT curriculum within the target UAA health professional programs (nursing, social work, and psychology) and the Alaska Family Medicine Residency program by augmenting existing training in substance abuse prevention and treatment, and by providing rurally tailored and culturally competent case studies, simulation experiences, and practicum opportunities to improve knowledge, attitude and behavior;
2. Increase collaboration among campus partners by assuring representation of diverse health professions in planning, and on the project’s Council of Directors (COD).
3. Assure students are provided with SBIRT education that is relevant to their respective disciplines and also rurally tailored and culturally and linguistically appropriate, both within the classroom and in practice settings;
4. Disseminate SBIRT education to expand the reach of SBIRT to a broader number of disciplines (e.g., physician assistants, dental hygienists) by expanding the COD and sharing outcomes and lessons learned during the grant period, as well as offering training through existing faculty development programs;
5. Disseminate SBIRT-related stories to increase adoption of SBIRT in clinical settings, by sharing success stories from organizations and students using SBIRT, hosting regional trainings and webinars, and engaging media to heighten awareness of the feasibility and effectiveness of SBIRT in routine clinical practice.
6. Establish institutional policies to sustain the inclusion of the SBIRT curriculum as a component of graduation requirements and to assure the ongoing training of health professionals beyond the grant.

**Program Partners.**

At the beginning of the project, Arctic SBIRT Training secured partnerships with the following groups or organizations:

- University of Alaska Anchorage
  - College of Health Interprofessional Health Sciences Simulation Center
  - Department of Psychology
  - School of Nursing
The project also had the benefit of receiving ongoing consultation from Dr. Jason Satterfield of the University of California San Francisco. Dr. Satterfield is a past and current recipient of a SAMHSA award to implement an SBIRT training program within the medical residency, nursing, and social work programs at UCSF.

Representatives from these groups or organizations participated on the Council of Directors, providing guidance and advice on implementing our goals and objectives.
### Appendix 2: Case Studies/Interprofessional Simulation Script Catalog

**Nursing**

<table>
<thead>
<tr>
<th>Name</th>
<th>Focus</th>
<th>Demographics</th>
<th>Tool</th>
<th>Level of use</th>
<th>Skill focus</th>
<th>Other information</th>
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<tbody>
<tr>
<td>Michael Smith</td>
<td>ETOH</td>
<td>23 yo male, ETOH related accident</td>
<td>AUDIT</td>
<td>heavy user/ binge drinker</td>
<td>BNI</td>
<td></td>
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<td>Samantha Smith</td>
<td>ETOH</td>
<td>25-35 yo female, Just found out she's pregnant</td>
<td>AUDIT</td>
<td>Light user, but pregnant</td>
<td>Education/ BNI</td>
<td>Experiencing abdominal/ pelvic pain</td>
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<td>George Olson</td>
<td>ETOH</td>
<td>73 yo male, recently lost his wife. Medication check-in</td>
<td>AUDIT</td>
<td>0- abstains</td>
<td></td>
<td>Previously dependent. George is worried he will relapse into substance use</td>
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<td>Monica Anderson</td>
<td>ETOH</td>
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<td>AUDIT</td>
<td>Heavy use</td>
<td>BNI</td>
<td>Possible depression</td>
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<td>Joanna/ John Roberts</td>
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<td>BNI</td>
<td>Open to information</td>
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<td>Alexis Johnson</td>
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<td>AUDIT</td>
<td>24 (dependent)</td>
<td>BNI/ referral to treatment</td>
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**Psychology**

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<tr>
<th>Name</th>
<th>Focus</th>
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<th>Tool</th>
<th>Level of use</th>
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<tr>
<td>George Olson</td>
<td>ETOH</td>
<td>73 yo male, lost his wife/ anxiety</td>
<td>AUDIT</td>
<td>0/0</td>
<td>Prior alcohol dependence</td>
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<tr>
<td>Jackson Wells</td>
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<td>54 yo male, depression/ anxiety</td>
<td>AUDIT</td>
<td>0/0</td>
<td>Prior alcohol dependence</td>
<td></td>
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<td>Kyle Martin</td>
<td>ETOH</td>
<td>17 yo male, anxiety</td>
<td>AUDIT</td>
<td>3 (low risk)/ 1 (low level)</td>
<td>Education</td>
<td>Harm reduction</td>
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<tr>
<td>Matt Hayes</td>
<td>ETOH/ marijuana</td>
<td>38 yo male, psychosomatic complaints</td>
<td>AUDIT/DAST</td>
<td>17 (higher risk)/ 7 (substantial level)</td>
<td>BNI/ referral to treatment</td>
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<td>Focus</td>
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<td>Tool</td>
<td>Level of use</td>
<td>Skill focus</td>
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<td>17 (higher risk)/ 7 (substantial level)</td>
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<td>BNI/ referral to treatment</td>
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<tr>
<td>Monica Anderson</td>
<td>ETOH</td>
<td>40 yo female, lost job, marital conflict, etc.</td>
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<td>11 (at risk)/ 0</td>
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**Social Work**

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<thead>
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<th>Level of use</th>
<th>Skill focus</th>
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<td>ETOH</td>
<td>54 yo male, depression/ anxiety</td>
<td>AUDIT</td>
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<td>Prior alcohol dependence</td>
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<tr>
<td>Kyle Martin</td>
<td>ETOH</td>
<td>17 yo male, anxiety</td>
<td>AUDIT</td>
<td>3 (low risk)/ 1 (low level)</td>
<td>education</td>
<td>Harm reduction</td>
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<tr>
<td>Matt Hayes</td>
<td>ETOH/ marijuana</td>
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<td>17 (higher risk)/ 7 (substantial level)</td>
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<td>Monica Anderson</td>
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## Appendix 3: Council of Directors (CoD) and Key Stakeholders

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<tr>
<td>Diane Casto</td>
<td>State of Alaska Division of Behavioral Health Prevention and Early Intervention Services</td>
<td>Policy Partner</td>
</tr>
<tr>
<td>Sarah Dewane</td>
<td>Alaska Family Medicine Residency/Providence Family Medicine Clinic</td>
<td>Academic Program Partner/Healthcare Partner</td>
</tr>
<tr>
<td>Gloria Eldridge</td>
<td>College of Arts and Sciences Department of Psychology (MS)</td>
<td>Academic Program Partner</td>
</tr>
<tr>
<td>James Fitterling</td>
<td>College of Arts and Sciences Department of Psychology (PhD)</td>
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<tr>
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<tr>
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<td>Academic Program Partner</td>
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<tr>
<td>Maureen O’Malley</td>
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</tr>
<tr>
<td>Rhonda Richtsmeier</td>
<td>State of Alaska Division of Public Health Public Health Nursing</td>
<td>Healthcare Partners</td>
</tr>
<tr>
<td>Jason Satterfield</td>
<td>University of California San Francisco</td>
<td>Expert SBIRT implementation consultant</td>
</tr>
<tr>
<td>Alan Shear</td>
<td>Yukon Kuskokwim Health Corporation (YKHC)</td>
<td>SBIRT training, advising</td>
</tr>
<tr>
<td>Ryan Shercliffe</td>
<td>College of Health Interprofessional Health Sciences Simulation Center</td>
<td>Interdisciplinary Simulation Coordination</td>
</tr>
<tr>
<td>Elizabeth Sirles</td>
<td>College of Health School of Social Work</td>
<td>Academic Program Partner</td>
</tr>
<tr>
<td>Richard (Rusty) Tews</td>
<td>Yukon Kuskokwim Health Corporation (YKHC)</td>
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</tr>
<tr>
<td>Alexa Filanowicz</td>
<td>College of Health School of Social Work</td>
<td>Academic Program Partner</td>
</tr>
<tr>
<td>Virginia Parret</td>
<td>Alaska Family Medicine Residency/Providence Family Medicine Clinic</td>
<td>Academic Program Partner/Healthcare Partner</td>
</tr>
</tbody>
</table>
Appendix 4: Evaluation Surveys

KAB Survey

Please choose the response that best completes each question.

1. How familiar are you with “SBIRT”?
   a. I’ve never heard of it.
   b. I’ve heard of it, but I don’t know much about it.
   c. I’ve learned about it, but I’ve never practiced it.
   d. I’ve learned about it and practiced it (e.g. role play, simulation, practice with patient).

2. What does the acronym SBIRT stand for?
   a. Screening, Binging, Reduction through Treatment
   b. Screening, Brief Intervention, Referral to Treatment
   c. Substance Use, Brief Intervention, Referral to Treatment
   d. Smoking, Binging, Interest in Reducing Toxins

3. Why is SBIRT important for payers, policymakers, and health professionals?
   a. By implementing a screening measure, SBIRT decreases professionals’ overall workload.
   b. SBIRT reduces professionals’ contact time with their patients.
   c. Unhealthy alcohol and drug use are major preventable and costly public health problems.
   d. Substance abuse prevention is currently the top public health initiative in the United States.

4. Why is SBIRT important for patients?
   a. The effects of substance abuse contribute to social, physical, and mental health problems.
   b. Substance abuse is the highest leading cause of death in North America.
   c. Patients can readily self-administer all four components of SBIRT.
   d. All of the above.

5. Research and experiential evidence shows that SBIRT is most effective…
   a. For persons with substance use disorders.
   b. For persons with risky behaviors.
   c. In one or two settings, such as a behavioral health clinic or a community health center.
   d. All of the above

6. Why is universal screening important?
   a. Federal healthcare regulations require universal screenings.
   b. Universal screening detects health problems related to at-risk alcohol and substance use before they develop into more severe health problems.
   c. Universal screening allows providers to understand the impact of alcohol and substance use on injury and illness.
   d. All of the above.

7. Which of the following best describes the physical health impacts of alcohol and drugs?
   a. Drugs and alcohol affect nearly all systems of the body.
   b. Drugs and alcohol affect the liver and respiratory system.
   c. Drugs and alcohol affect the brain and central nervous system.
   d. Drugs and alcohol affect the brain and endocrine system.
8. What are the daily/weekly alcohol use risk limits for men?
   a. No more than 1 drink per day/7 drinks per week
   b. No more than 2 drinks per day/14 drinks per week
   c. No more than 3 drinks per day/21 drinks per week
   d. No more than 4 drinks per day/28 drinks per week

9. What constitutes an at-risk **binge** drinking session for a woman?
   a. 3 or more drinks
   b. 4 or more drinks
   c. 5 or more drinks
   d. 6 or more drinks

10. When using the DAST (10) to screen for drug abuse, what score(s) require action on behalf of a health care professional?
    a. 1-10
    b. 3-10
    c. 6-10
    d. 8-10

11. What is Motivational Interviewing?
    a. A direct teaching strategy for reinforcing coping skills and internal motivational change.
    b. A non-directive strategy used to reshape cognitions and establish change through extrinsic means.
    c. Patient-centered, directive method for enhancing intrinsic motivation to change by resolving ambivalence.
    d. Patient-centered counselling techniques used to promote determination and self-actualization.

12. In Motivational Interviewing, the task of “focus” can be described as…
    a. Focus on the universal goal of improved health and well-being.
    b. Focus on what is important to the patient.
    c. Focus on the prescription for change.
    d. All of the above.

13. Which of the following is an expression of empathy?
    a. “I’ve been where you are and I suggest you think of your family.”
    b. “I can see why you would feel that way.”
    c. “We all struggle sometimes and focusing on the future can help.”
    d. All of the above

14. What is the final step in the Motivational Interviewing process?
    a. Evoke intrinsic motivations for change from the patient.
    b. Facilitate the process for the patient to make a plan.
    c. Affirm what the patient said.
    d. Ask the patient to sign a change contract.

15. What are the core skills of Motivational Interviewing?
    a. Questions, Directions, Repetition, Closing
    b. Ongoing dialogue, Asking questions, Re-education, Synopsis
c. Open questions, Affirmations, Reflective listening, Summaries
d. Open questions, Attitude formation, Realignment, Steps

16. What stage of change is marked by the patient seeing the possibility for change but being uncertain?
   a. Precontemplation
   b. Contemplation
   c. Ambivalence
   d. Action

17. What is a brief intervention?
   a. A directive counseling session for problematic substance users to evoke change and resolution.
   b. A short motivational and awareness-raising intervention with at-risk or problematic substance users.
   c. A concise motivational and directive intervention with problematic substance users.
   d. An acute treatment for substance abusers who solicit professional advice and resources.

18. What is the BNI (brief negotiation interview)?
   a. A structured interview alternative to motivational interviewing.
   b. An evidence-based example of brief intervention.
   c. A 10-step process for engaging patients and motivating change.
   d. All of the above.

19. When providing a referral, the __________ the handoff, the better the outcome.
   a. Warmer
   b. Longer
   c. More direct
   d. More formal

20. Which of the following is true about treatment?
   a. Inpatient treatment can be useful for individuals at any level of risk or abuse.
   b. Within primary care, brief treatment involving up to 12 sessions of motivational interviewing can be successful for many patients.
   c. Quality substance abuse treatment facilities will not provide updates or share discharge information with primary care providers.
   d. All of the above are true.

Using a scale from 1 (no responsibility) to 5 (major responsibility), describe your responsibility as a healthcare professional to...

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>No Responsibility</th>
<th>Major Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask patients about their alcohol use</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Use a standardized screener to assess alcohol use</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Assess patients’ readiness to change their alcohol use behavior</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discuss/advice patients to change their alcohol use behavior</td>
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<td></td>
</tr>
<tr>
<td>Refer patients with alcohol use problems</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Document your assessment, intervention, and referral related to patients’ alcohol use</td>
<td>1</td>
<td></td>
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</table>
### Drug Use

<table>
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<tr>
<th>Activity</th>
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</tr>
</thead>
<tbody>
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<td>Ask patients about their drug use</td>
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<td>2 3 4 5</td>
</tr>
<tr>
<td>Use a standardized screener to assess drug use</td>
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<td>2 3 4 5</td>
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<tr>
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<tr>
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<td>2 3 4 5</td>
</tr>
</tbody>
</table>

### Alcohol

<table>
<thead>
<tr>
<th>Activity</th>
<th>No Confidence</th>
<th>High Confidence</th>
</tr>
</thead>
<tbody>
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</tr>
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### Using a scale from 1 (no confidence) to 5 (high confidence), how confident are you in your ability to…

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Using a scale from 1 (no confidence) to 5 (high confidence), how confident are you in your ability to…

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<tr>
<td>Document your assessment, intervention, and referral related to patients’ alcohol use</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
</tbody>
</table>
Using a scale from 1 (strongly disagree) to 5 (strongly agree), rate your agreement with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking to patients about their alcohol/drug use makes me feel like a responsible healthcare professional.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It takes too much time to deal with patients’ alcohol/drug behavior.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are no/few adequate places to refer patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Advising patients about their alcohol/drug use behaviors may lead to early, successful interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are too many legal issues regarding alcohol/drug use and documentation to get involved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are no/few role models who address alcohol/drug use in my organization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Patients will be angry if I ask these questions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Patients with alcohol/drug problems cause behavioral problems in the clinic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People can stop abusing alcohol/drugs if they really want to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Treatment doesn’t work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Referrals have not helped many patients in the past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My involvement with a patient can make a difference in their alcohol/drug use behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SAMHSA TRAINING SATISFACTION SURVEY

Please check here ( ) if you have received this survey in error, (i.e., you did not attend the training listed above) and return the uncompleted survey.

PLEASE BASE YOUR ANSWER ON HOW YOU FEEL ABOUT THE (SBIRT TRAINING) NOW.

1. How satisfied are you with the overall quality of this training?
2. How satisfied are you with the quality of the instruction?
3. How satisfied are you with the quality of the training materials?
4. Overall, how satisfied are you with your training experience?

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE (SBIRT TRAINING).

5. The training class was well organized.
6. The material presented in this class will be useful to me in dealing with substance abuse.
7. The instructor was knowledgeable about the subject matter.
8. The instructor was well prepared for the course.
9. The instructor was receptive to participant comments and questions.
10. I am currently effective when working in this topic area.
11. The training enhanced my skills in this topic area.
12. The training was relevant to my career.
13. I expect to use the information gained from this training.
14. I expect this training to benefit my clients.
15. This training was relevant to substance abuse treatment.
16. I would recommend this training to a colleague.
17. How useful was the information you received from the instructor? 

<table>
<thead>
<tr>
<th>Very Useful</th>
<th>Useful</th>
<th>Neutral</th>
<th>Useless</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

18. Please indicate which title best describes your job:
- ___Medical Director
- ___Clinical Administrator/Manager
- ___Federal Government Official
- ___Physician
- ___Clinical Supervisor
- ___State Government Official
- ___Nurse
- ___Psychologist
- ___County Government Official
- ___Physician's Assistant
- ___Counselor
- ___Researcher
- ___Pharmacist
- ___Social Worker
- ___Other (please specify)________
- ___Manager/Director
- ___Other (please describe)
- ___Other (please specify)________

19. Please indicate which best describes your agency or affiliation:
- ___Federal Government
- ___Substance Abuse Treatment Program
- ___State Government
- ___University or other higher education institution
- ___County Government
- ___Other (please describe)________________________
- ___Local Government

20. What is your gender? 1.____Male 2.____Female

21. Are you Hispanic or Latino? 1.____Yes 2.____No

22. What is your race (Mark all that apply)?
- ___Black or African American
- ___Alaska Native
- ___Asian
- ___American Indian
- ___White
- ___Native Hawaiian or Other Pacific Islander

What about the (SBIRT) training was most useful in supporting your work responsibilities?

How can CSAT improve the (SBIRT) Training?

Thank you for completing our survey.
Return your survey to the Survey Administrator for your Session.
Post-Graduation Survey

Q1. Are you a current student?
   Yes.
   No. [skip to Q2]

   Q1a. What school are you attending?
        UAA
        UAF
        UAS
        Other (Specify)

   Q1b. What is your current educational goal?
        degree seeking
        non-degree seeking [if non-degree seeking, skip to Q2]

   Q1c. What is your current area of study?
        Nursing
        Social Work
        Psychology
        Medical School
        Other (specify)

   Q1d. What degree are you seeking?
        Associates
        Undergraduate
        Masters
        PhD
        MD
        Other (specify)

   Q1d. Are you currently in a practicum or internship?
        Yes.
        No.

Q2. What is your current employment status?
   Employed (either full-time or part-time) in my degree field
   Employed (either full-time or part-time) in a field OTHER than my degree focus
   Unemployed [Skip to Q3]

   [skip to Q10 if Q1d “no” and Q2 “unemployed”]

   Q2a. In what state are you employed?
        Alaska
        Other (specify) [skip to Q2c]

   Q2b. In what city are you employed?
        Anchorage
        Fairbanks
        Juneau
        Palmer
        Wasilla
        Other (specify)
**Q2c.** Where are you employed?

**Q2c.** What is your job title?

**Q3.** Is SBIRT used in your current place of employment or practicum / internship? (regardless of whether you use it personally)
- Yes, it is standard practice for all patients. [Skip to Q5]
- Yes, it is encouraged for all/most patients. [Skip to Q4]
- Yes, it is available for use at the discretion of the clinician/provider. [Skip to Q4]
- No.

**Q3a.** Is there talk of using SBIRT in the future?
- Yes.
- No.

**Q4.** If your current place of employment or practicum / internship site has not adopted SBIRT as standard practice (i.e. universal for all patients), is there another universal screening or intervention used with patients/clients who misuse alcohol and/or drugs?
- Yes.
- No. [Skip to Q5]

**Q4a.** Briefly describe this universal screening or intervention.

**Q5.** Have you received on-the-job SBIRT training at your current place of employment?
- Yes.
- No.

**Q6.** Do you currently interact with patients or clients?
- Yes, as part of current job
- Yes, as part of practicum / internship
- Yes, for both a current job and practicum / internship
- No. [Skip to Q10]

**Q6a.** Briefly describe your typical interaction with patients/clients.

**Q7.** Do you currently provide SBIRT to your patients or clients?
- Yes, all patients/clients. [skip to Q7b]
- Yes, some patients/clients.
- No. [skip to Q10]

**Q7a.** Describe when you use SBIRT.

**Q7b.** Which parts do you personally conduct? (Choose all that apply.)
- Screening.
- Brief Intervention.
- Referral to treatment.

**Q8.** How effective is SBIRT for your patients/clients?
- Not at all effective
- A little effective
- Somewhat effective
- Mostly effective
Extremely effective

Q9. Please provide any comments about SBIRT and its usefulness in your current position or practicum/internship.

Q10. Since graduation, have you used SBIRT in any way other than through a current job or practicum/internship?
   - Yes.
   - No. [Skip to Q11a]

   Q10a. Please describe.

Confidence and Responsibility

Using a scale from 1 (no responsibility) to 5 (major responsibility), describe your responsibility as a healthcare professional to…

<table>
<thead>
<tr>
<th>Q11a-11f. Alcohol</th>
<th>No Responsibility</th>
<th>Major Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask patients about their alcohol use</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Use a standardized screener to assess alcohol use</td>
<td>1</td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Q12a-12f. Drug Use</th>
<th>No Responsibility</th>
<th>Major Responsibility</th>
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<tbody>
<tr>
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Using a scale from 1 (no confidence) to 5 (high confidence), how confident are you in your ability to…

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<thead>
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<th>Q13a-13f. Alcohol</th>
<th>No Confidence</th>
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</tr>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Refer patients with alcohol use problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Document your assessment, intervention, and referral related to patients’ alcohol use</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### Q14a-14f. Drug Use

<table>
<thead>
<tr>
<th>Item</th>
<th>No Confidence</th>
<th>High Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask patients about their drug use</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Use a standardized screener to assess drug use</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Assess patients’ readiness to change their drug use behavior</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Discuss/advise patients to change their drug use behavior</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Refer patients with drug use problems</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Document your assessment, intervention, and referral related to patients’ drug use</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Using a scale from 1 (strongly disagree) to 5 (strongly agree), rate your agreement with the following statements.

### Q15a-15l.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking to patients about their alcohol/drug use makes me feel like a responsible healthcare professional.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It takes too much time to deal with patients’ alcohol/drug behavior.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are no/few adequate places to refer patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Advising patients about their alcohol/drug use behaviors may lead to early, successful interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are too many legal issues regarding alcohol/drug use and documentation to get involved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are no/few role models who address alcohol/drug use in my organization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Patients will be angry if I ask these questions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Patients with alcohol/drug problems cause behavioral problems in the clinic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People can stop abusing alcohol/drugs if they really want to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Treatment doesn’t work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Referrals have not helped many patients in the past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My involvement with a patient can make a difference in their alcohol/drug use behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 5: Project Staff

Project Director: Diane King

Project Manager: Alexandra Edwards

Evaluation Director: Bridget Hanson

Project Analyst/Evaluation Lead: Jodi Barnett

Project Specialist: Emilie Cattrell

Interprofessional Simulation Center Manager: Ryan Shercliffe

Graduate Research Assistant: Lucia Neander

Graduate Student Assistant: Laila Allen

Graduate Student Assistant: Lauren Mitchell

Graduate Research Assistant: Amanda Elkins