ABSTRACT

Background: Substance use disorders are a major public health problem. As primary care providers, nurse practitioners (NPs) must be proficient at screening, identifying, and intervening for at-risk patients. Screening, brief intervention, and referral to treatment (SBIRT) is a well-established, evidence-based model for teaching behavioral health skills to health care providers. It is vital that Master of Science in Nursing (MSN)-NP programs incorporate SBIRT into their curricula. Method: SBIRT content was mapped to 10 courses across an MSN-NP program. Methods of integration included readings, lectures, case studies, role-plays, tutorials, symposia, and test questions, as well as tracking the use of SBIRT during clinical preceptorships. Results: A total of 139 online and on-campus MSN-NP students were trained. Data demonstrate students successfully implemented SBIRT in precepted clinical settings. Conclusion: This approach provides a framework for integrating SBIRT training into MSN-NP curricula. [J Nurs Educ. 2017;56(12):725-732.]

Nurse practitioners (NPs) traditionally have been educated and tested on a theoretical understanding of behavioral health and substance use disorders. Yet, too often, their curricula lack adequate opportunities to learn and practice the skills required to intervene effectively with patients at risk for these common morbidities. Emerging research has demonstrated that new approaches to the identification and early management of a wide range of behavioral health problems are effective and can be taught to health care providers without significant psychiatric training (Aveyard et al., 2016; Lamars, Jonkers, Bosma, Knottnerus, & Van Eijk, 2011; McNaughton, 2009; Nelson & Thomas, 2007; Walton et al., 2010). These approaches teach core behavioral skills such as interviewing, goal setting, cognitive behavioral techniques, and collaboration. Providing NP students with repeated opportunities to learn and practice these requisite skills during their educational programs is a necessary first step in preparing graduates to embrace a wider role in managing behavioral problems affecting the health of this nation.

One widely endorsed model of teaching these skills to health care providers is screening, brief intervention, and referral to treatment (SBIRT). This is an evidence-based process designed to (a) screen for individuals at risk for substance use disorders, (b) implement a brief intervention such as a brief negotiated interview (BNI), and (c) refer to higher levels of treatment to maximize opportunities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012a). SBIRT is "a comprehensive public health approach for delivering early intervention and treatment services to people with, or at risk of developing, substance use disorders” (SAMHSA, 2012a, p. 1).

IMPORTANCE OF SBIRT

The SBIRT process was developed in response to a major public health problem: substance use disorders. Based on a 2014 national survey of 2.65 million respondents ages 12 and older, 49.2% indicated they had used illicit drugs during their lifetime, 16.7% indicated they had used illicit drugs in the past year, and 10.2% indicated that they had used illicit drugs in the past month (SAMHSA, 2015). In the same year, 52.7% of respondents indicated they had used alcohol in the past month. Of those, 23% indicated they had five or more drinks on the same occasion on at least 1 day in the past 30 days, and 6.2%
indicated they had five or more drinks on the same occasion on each of 5 or more days in the past 30 days (SAMHSA, 2015). Alcohol use disorders result in approximately 88,000 deaths each year, and pregnant women who abuse substances can deliver babies with alcohol-related neurodevelopmental disorders and alcohol-related birth defects (Centers for Disease Control and Prevention [CDC], 2015). Equally alarming is the finding that there has been a five-fold increase in maternal opioid use and neonatal abstinence syndrome. The National Institute on Drug Abuse (NIDA) (2012) estimates that every 25 minutes, a baby with opioid withdrawal is born. Another concern is the increase in opioid misuse, with an estimated 4.3 million Americans using prescription painkillers for nonmedical reasons each month (CDC, 2016).

OVERVIEW OF SBIRT

The intent of SBIRT is to provide secondary prevention via universal screening to allow health care professionals to address the spectrum of substance use disorders even if the patient is not seeking treatment or is not aware that a problem exists. Screening quickly identifies patients at risk and the appropriate level of intervention needed for harm reduction (SAMHSA, 2012b). If screening is positive, the clinician administers a BNI, which is a short counseling technique based on behavioral change theory and motivational interviewing principles. A BNI is designed to (a) facilitate patient awareness of his or her substance use disorder, (b) provide feedback about the patient’s behavior to facilitate the patient’s ambivalence regarding implementation of a behavioral change, (c) enhance motivation by assessing readiness to change and summarizing, and (d) negotiate a plan (Miller & Rollnick, 1991).

The principles of motivational interviewing are applicable to numerous health problems requiring a behavioral change. Therefore, this skill can be used to address many health care issues that patients may present with, not just those with substance use disorders. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care (SAMHSA, 2017). Research has confirmed the benefits of SBIRT (Academic Emergency Department SBIRT Research Collaborative, 2010; Ettner et al., 2006; Kaner et al., 2009; Madras et al., 2009; Sullivan, Tetrault, Braithwaite, Turner, & Fiellin, 2011).

The primary care setting provides the greatest opportunity to screen and intervene for those with substance use disorders. In this setting, the NP should be screening, providing BNIs as needed, and referring to treatment patients with problems whose complexity or resistance to BNI requires more intensive treatment. Therefore, there is a great need for the NP to be proficient in these processes.

CURRICULAR NEEDS

Of necessity, NP curricula have begun to adapt and expand to include new skills that will better equip providers to respond to the morbidities currently challenging the health of the population. Chronic diseases such as substance use disorders are “the public health challenge of the 21st century,” (CDC, 2009, p. 1). The Patient Protection and Affordable Care Act (2010) and the national call for the integration of population health and traditional primary care competencies by the Institute of Medicine (2012) also inform curricular needs and necessary skill sets for the NP of the future. Recognition of the vital importance of population health competencies for primary care providers is resulting in significant curricular changes in programs preparing NPs as primary care providers. Integrating SBIRT into an NP program of study is but one significant curricular change to address these issues.

INTEGRATING SBIRT TRAINING INTO A PROGRAM

SBIRT training was integrated throughout the Master of Science in Nursing (MSN)-NP (adult-gerontology NP, family NP, and pediatric NP) programs at a private university. SBIRT training focused on discussing the types and prevalence of substance use disorders, teaching the SBIRT approach, and providing opportunities for SBIRT practice through role-play, simulations, and within clinical practice.

This article initially discusses the training of faculty and preceptors to support curriculum SBIRT content. In addition, the development of curriculum content is described, as well as how the content was integrated into courses across the MSN-NP program. Finally, the process of documenting use in clinical practice and the results of the first year are presented.

TRAINING OF FACULTY AND PRECEPTORS

The MSN-NP SBIRT curriculum was developed entirely within the context of a 3-year interprofessional, collaborative training project between the schools of social work and nursing to provide training to students, faculty, field instructors, clinical preceptors, community providers, and administrators. The project trained approximately 600 students; of these, 139 were MSN-NP on-campus and online students. The training was a component of a larger funded training grant, which was approved by the university’s institutional review board. All faculty and students were informed of the training grant prior to participation. The expected outcome was to educate graduate students and faculty, promote behavioral change in patients, influence practice in the community, and facilitate the incorporation of SBIRT into standards of care.

Faculty Training

The initial training focused on four MSN-NP faculty who were designated as the “SBIRT experts.” SAMHSA, Programs and Campaigns (2013), provided access to training videos on the overall purpose of SBIRT, its efforts to reduce harm, established criteria for at-risk drinking, screening for substance use disorders, the BNI, and treatment referral processes. To supplement these videos, SAMHSA provided funding for additional interprofessional training by national experts. The experts were psychologists, physicians, social workers, and nurses who provided training in substance abuse disorders, motivational interviewing, and interprofessional collaboration to the MSN faculty, as well as the School of Social Service Master of Social Work (MSW) faculty. Faculty practiced screening and
BNI skills through role-playing. Finally, faculty were provided additional Web-based resources including an interactive portal for practicing use of SBIRT with an online simulated patient. Faculty rated the training as highly satisfactory and indicated that SBIRT teaching was relevant to the graduate NP students.

The four SBIRT expert faculty were responsible for training all MSN faculty and developed a train-the-trainers plan to ensure MSN faculty were prepared to teach SBIRT across the curriculum. For the training, the faculty (both on-campus and online) initially reviewed online modules. Thereafter, the faculty observed two SBIRT expert faculty teach the SBIRT content, and finally, the faculty participated in teaching the SBIRT content with an SBIRT expert faculty. Online faculty did not directly engage in teaching the SBIRT content because it was presented in prerecorded videos developed by one of the SBIRT expert faculty. The prerecorded lectures were available for online faculty to review, and they were expected to respond to any questions students posed regarding SBIRT content.

Clinical Preceptor Training
Clinical preceptors were critical stakeholders to ensure a strong connection between the classroom and clinical experiences as success depended on students’ abilities to use SBIRT in their clinical practica. Students needed opportunities to be able to screen patients, implement BNIs with at-risk patients, and refer patients who were in need of more extensive services. Moreover, clinical preceptors needed to be trained so that students in their practice settings would be guided by preceptors with the same knowledge base. To facilitate preceptor buy-in, local preceptors were invited to an annual on-campus training event. The event included an overview of SBIRT and instruction in the three major components (screening, brief intervention, and referral to treatment) and also highlighted the significance of incorporating SBIRT into practice. However, to expand community outreach beyond preceptors to other clinical staff, free SBIRT training was offered to clinical site personnel at their request. To date, only one SBIRT training has been provided at a designated clinical site. Anecdotally, the recipients were highly satisfied with the training, and the facility leadership has requested continued training with additional staff.

Each year, preceptors were invited to attend a 1-day SBIRT conference with national and local experts. The preceptors were not required to pay any registration fees, and they received contact hours for attendance. This event allowed the university to maintain a collaborative relationship with the preceptors, to provide time for faculty to interact with the preceptors and discuss any issues, and to thank the preceptors for their support by investing time and energy in SBIRT training and implementing it in their practice.

DEVELOPMENT AND INTEGRATION OF CURRICULUM CONTENT

Prior to SBIRT Integration
Prior to implementing SBIRT into the MSN-NP curriculum, course content related to the identification and treatment of patients who misuse alcohol or drugs was limited. In the first semester, students were introduced to two screening tools in the Advanced Health Assessment course. This was followed by a single lecture on interviewing patients regarding substance abuse in the core Health Promotion course during the second semester. Student evaluations highlighted inadequacies in their skills in this area. During faculty observations of NP students performing history-taking on patients who disclosed substance use, students almost uniformly failed to follow up and to follow through on these disclosures. Moreover, students who demonstrated theoretical knowledge of recommended approaches on a written test lacked the skills necessary to address substance use disorders effectively in practice settings.

SBIRT Integration
Faculty on the original collaborative training project served as the curriculum committee for integrating SBIRT content. During the first 6 months of the first year, faculty reviewed SBIRT content based on a literature review, materials provided by SAMHSA, and national expert presentations. Thereafter, relevant content was identified, streamlined, and tailored to the objectives of the MSN-NP program. Upon completion, the major components of SBIRT were mapped to 10 courses in the MSN-NP program (Table 1). For integration, the course content was modified to facilitate the integration of SBIRT information.

Advanced Health Assessment. Students were introduced to SBIRT during their first clinical course, Advanced Health Assessment. Students viewed two tutorials that introduced the SBIRT approach and alcohol-related concepts such as a standard drink, the National Institute on Alcohol Abuse and Alcoholism’s (NIAAA, 2016) established criteria for at-risk drinking, and the distinction between alcohol abuse, alcohol dependence, and at-risk drinking.

Students were taught how to screen patients for substance use disorders in a clinical setting and how to universally screen all patients for substance use disorders using the NIAAA (2007) and NIDA (2012) single-question screening tests. If a patient screened positive, students were taught to further evaluate the patient’s alcohol and drug use with a standardized risk assessment tool such as:

- Alcohol Use Disorder Identification Test-Consumption (AUDIT-C).
- Drug Abuse Screening Test (DAST).
- Concern/Cut-down, Anger, Guilt, and Eye-opener (CAGE/CAGE-AID).
- Care, Relax, Alone, Forget, Friends, and Trouble (CRAFFT).

The AUDIT-C is composed of the first three questions of the longer AUDIT (Babor, de la Fuente, Saunders, & Grant, 1989) and targets identification of hazardous alcohol use (Dawson, Grant, Stinson, & Zhou, 2005). A positive AUDIT-C may lead to more thorough screening with the AUDIT, a 10-item alcohol screening instrument developed by the World Health Organization that has been validated in a variety of settings and cultures (Babor et al., 1989; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). The DAST is a 10-item screening tool for the use of drugs (Skinner, 1982). CAGE is an acronym for its four questions about “Concern/Cut-down, Anger, Guilt, and Eye-opener” related to drinking (Ewing, 1984). A variation, the CAGE-AID, substitutes “drink” with “drink or drugs” in each of the four questions.
questions. The CRAFFT is an acronym for six topics (Care, Relax, Alone, Forget, Friends, and Trouble); this tool is a series of six questions developed to screen adolescents for high-risk alcohol and other drug use disorders simultaneously (Knight et al., 1999). High sensitivity and specificity in detecting substance use disorders have been demonstrated by the AUDIT (Richoux et al., 2011), the AUDIT-C (Blank, Connor, Gray, & Tustin, 2015), DAST (Cuneyt et al., 2013), CAGE (Richoux et al., 2011), and CRAFFT (Knight, Sherritt, Harris, Gates, & Chang, 2003; Knight, Sherritt, Shrier, Harris, & Chang, 2002).

After receiving training on how to screen patients for substance use disorders, students were introduced to the concept of brief interventions such as the BNI. The BNI is based on the model of transtheoretical behavioral change (Prochaska & DiClemente, 1983) and motivational interviewing techniques (Miller & Rollnick, 1991). The BNI provides an efficient four-step method to perform a brief intervention (D’Onofrio, Panta- lon, Degutis, Fiellin, & O’Connor, 2005). Students were taught the following components: asking permission to raise the subject of substance use, providing feedback about the patient’s behavior to facilitate the patient’s ambivalence regarding implementation of a behavioral change, enhancing motivation by assessing readiness to change, summarizing, and negotiating a plan (D’Onofrio et al., 2005). Thereafter, students viewed demonstrations of the steps and techniques. Although the students did not practice these skills in this course, they were reintroduced to motivational interviewing the following semester in the Health Promotion course.

Theoretical Foundations. The transtheoretical model of behavioral change (Prochaska & DiClemente, 1983) was introduced in the Theoretical Foundations course as a model to conceptualize the process of intentional behavior change. The model is described in further detail with a focus on the stages of change in the Health Promotion course.

Health Promotion. In the Health Promotion course, stages of change and motivational interviewing were integrated into lectures on substance use disorders and other Healthy People 2020 (Office of Disease Prevention and Health Promotion, 2014) topic areas, such as overweight and obesity, physical activity, tobacco use, injury and violence, mental health, oral health, and occupational health. Students learned motivational interviewing as part of health promotion counseling. They practiced the BNI skills learned in Health Assessment using role-play with open-ended questions, affirmation, reflection, and summarizing (OARS). The students paired off and exchanged the roles of patient and NP. The students received information for each of their assigned roles and practiced in 20-minute role-playing sessions. Students were instructed to apply each step of the BNI process when serving in the role of NP.

Faculty observed the role-playing and offered suggestions and encouragement. Following completion of the role-playing sessions, faculty and students discussed the students’ reactions, and faculty presented additional information to overcome barriers encountered by students during the role-plays. In addition, students completed essay test questions about the application of motivational interviewing.

Adolescent Primary Care Seminar. In the Adolescent Primary Care Seminar course, stages of change and motivational interviewing were discussed again in relation to weight management, substance use, and risky behaviors typical of adolescents. The core components of SBIRT also were reviewed.

Primary Care of Adults I. In the Primary Care of Adults I course, students viewed three tutorials that reviewed motivational interviewing skills and strategies. They also reviewed the use of motivational interviewing in relation to alcohol, drug, and tobacco use, as well as weight management, exercise, and other health behaviors relevant to adults.

Primary Care of Adults II. In the Primary Care of Adults II course, students viewed two tutorials that reviewed the elements

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**TABLE 1**

Integration of SBIRT Components Into the MSN-NP Curriculum

<table>
<thead>
<tr>
<th>MSN Course</th>
<th>Credit Hours</th>
<th>SBIRT Overview</th>
<th>Screening</th>
<th>Brief Intervention</th>
<th>Referral to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Foundations</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>2</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Assessment</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Pediatric Nursing Seminar</td>
<td>1</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care of Adults I</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Primary Care of Adults II</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>NP Practicum I</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>NP Practicum II</td>
<td>2</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>NP Practicum III</td>
<td>2</td>
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<td></td>
<td>X</td>
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</tbody>
</table>

Note. MSN = Master of Science in Nursing; NP = nurse practitioner; SBIRT = screening, brief intervention, and referral to treatment.
of the BNI and referral of patients to treatment. Students were introduced to various referral resources such as local inpatient and outpatient treatment services, rehabilitation centers, and support groups. Students were directed to training videos on treatment of substance use disorders from a variety of sources available in the public domain. Students were taught that selection of a referral source was dependent on additional patient factors such as comorbid conditions, patient preferences, family support, transportation, health insurance, primary language, disabilities, and other characteristics.

Referrals were completed in accordance with established clinical protocols and referral networks—for example, referring patients to a counselor who would contact local resources and schedule patients for follow-up, calling local substance abuse treatment services or providers and scheduling an appointment, or providing names of the services and providers to patients. Students also were taught how to seek referral services through the SAMHSA Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov).

In a substance use disorder module, students studied peer-reviewed journal articles and tutorials that explored all three SBIRT core components. Moreover, the students were provided with information on current procedural terminology codes assigned for screening and brief intervention, state laws regarding legal alcohol limits and age restrictions, and state laws regarding insurance companies’ practices for reimbursement for SBIRT performance. Students were required to complete a U.S. Food and Drug Administration (USFDA) online Risk Evaluation and Mitigation Strategy (REMS) training (D’Arcy & Hudspeth, 2017; USFDA, 2017), and they practiced applying SBIRT concepts to substance use disorder case scenarios via faculty-guided case study analyses.

**Pharmacology:** In the Pharmacology course, students reviewed the mechanisms of action, recommended dosing, potential side effects, and clinical applications of controlled substances including pain, behavioral, and mental health medications. The five Drug Enforcement Agency controlled substance schedules were reviewed. Prescribing responsibility and the issues surrounding patients with drug-seeking behaviors were discussed.

**Clinical Courses.** In the clinical courses (NP Practicum I, II, and III) and the courses with precepted clinical components (Primary Care of Adults I and II), students were encouraged to use the SBIRT approach in their precepted clinical settings. Because students might encounter barriers to using SBIRT, implementation of SBIRT in the clinical setting was not a requirement. To supplement clinical experiences, particularly in settings that posed significant barriers to practicing SBIRT, simulated case scenarios were created. The simulation laboratory provided students with additional opportunities to practice SBIRT and enabled faculty to directly evaluate students’ implementation of SBIRT.

Students documented all SBIRT clinical encounters using the Typhon Group’s NPST Student Tracking System Software. This system is configured to allow students to document when they screen a patient for substance use, perform a brief intervention, or refer a patient for treatment.

**Methods of Integration**

Methods of integration included use of readings, lectures, case studies, role-plays, symposia, simulations, tutorials, test questions, and tracking use of SBIRT during clinical preceptorships (Table 2). Based on the topic, the in-class and video-recorded lectures and tutorials were presented as 1-hour segments. With the incorporation of case studies and role-plays, an additional hour of teaching time was allocated (online students completed simulated case studies).

During the 3 years of the training grant, the on-campus students attended four 90-minute symposia: Symposium One,

<table>
<thead>
<tr>
<th>Table 2 Methods of Integrating SBIRT into the MSN-NP Curriculum</th>
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<tbody>
<tr>
<td><strong>Course</strong></td>
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<td></td>
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<tr>
<td>Theoretical Foundations</td>
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<tr>
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<tr>
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<td>NP Practicum II</td>
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<td>NP Practicum III</td>
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</tbody>
</table>

Note. MSN = Master of Science in Nursing; NP = nurse practitioner; SBIRT = screening, brief intervention, and referral to treatment.
Screening and Brief Negotiated Interview; Symposium Two, Brief Intervention; Symposium Three, Referral to Treatment; and Symposium Four, Ethics of SBIRT. The symposia were videotaped for the online students. After the closure of the training grant, the on-campus symposiums were discontinued, and the on-campus students also viewed the videotaped presentations of the symposiums.

Summary of the Integration
This diffusion of content across multiple courses with application to various populations and contexts facilitated and reinforced the students’ assimilation of knowledge and their use of SBIRT. In addition, throughout the program, students were directed to resources for additional information on SBIRT, BNI, motivational interviewing, and screening tools. For example, in the Health Assessment course, students were provided with an SBIRT pocket guide, which contained background information, screening tools, an overview of motivational interviewing, a BNI algorithm, and treatment locator resources.

Areas for improvement include the limited interaction in the online modules. To enhance learning and skill acquisition, modules should foster cognitive engagement and provide immediate feedback. Simulation-based practice exercises would facilitate enhanced interaction.

CLINICAL PRACTICE

The MSN-NP students document their clinical practice experiences using the Typhon Group’s (2017) NPST Student Tracking System for advanced practiced nursing. The NP students electronically record a log for every patient encounter, thus tracking clinical encounter information. The Web-based system allows faculty to monitor whether students are satisfactorily progressing in their clinical experiences and meeting their course objectives. In addition, the system facilitates the analysis of data (e.g., types of patients, procedural and diagnostic codes, total clinical hours, and total number of cases).

To track the use of SBIRT in precepted clinical settings, annotations for SBIRT screening, BNI, and SBIRT referral to treatment were added to the case log template. For each patient encounter, students were able to annotate whether they performed a screening, BNI, or referral to treatment. Because the students could only annotate one of these three measures, they were instructed to annotate at the highest level of intervention. For example, if a student annotated either an SBIRT BNI or a referral to treatment, it was assumed that the student had first completed screening.

Clinical Log Results
For the first cohort of students, the clinical logs were analyzed 7 months after incorporation of the three SBIRT tasks (screening, BNI, and referral to treatment) into the Typhon tracking system. The results indicated that both the on-campus and online students were implementing SBIRT components in clinical practice. Data for two semesters (spring and summer) were analyzed. Across the two semesters, six courses with a clinical component identified 17 students who had implemented SBIRT components. Fifteen students (88%) implemented screenings, with the number of completed screenings per student ranging from 1 to 195. In reference to BNIs, 10 students (59%) completed this component, and the number of completed BNIs per student ranged from 1 to 16. Finally, seven students (41%) completed referrals to treatment, with the number of completed referrals per student ranging from 1 to 3. Because the students were documenting at the highest level of intervention, student annotation of either “BNI” or “referral to treatment” implied that screening also had been completed. However, for analysis, only the highest level of intervention documented was included. The results demonstrate that students were implementing SBIRT in clinical settings.

Barriers to Implementation of SBIRT in Clinical Practica
Clinic-specific factors may have influenced how frequently students implemented SBIRT in the clinical setting. During future clinical site visits, instructors plan to query whether students are allowed to implement the three SBIRT tasks. Suspected barriers include provider attitudes and competence, workflow and resources, organizational support, and patient attitudes and background. Preceptors need to be queried regarding their awareness of SBIRT, their receptiveness to SBIRT, and their knowledge and skill set related to SBIRT. If SBIRT is not a standard of care in the clinical setting or if barriers exist that prevent the effective incorporation of SBIRT into clinical practice, faculty may need to partner with preceptors and clinical staff to implement change strategies for the effective integration of SBIRT into clinical agencies. Such collaboration would facilitate student opportunities to implement SBIRT in clinical settings.

CONCLUSION
To prevent the continued rise in incidence and the impact of substance abuse disorders, multiple organizations including SAMHSA, the U.S. Preventive Services Task Force (2004), and the Institute of Medicine (2012) endorse SBIRT for universal screening and management of such disorders. The incorporation of SBIRT demonstrates compliance with national requirements for NPs, as outlined in The Essentials of Master’s Education for Advanced Practice Nursing (American Association of Colleges of Nursing, 2011), that advanced practice nurses are competent in health promotion, disease prevention, and management of chronic conditions.

In addition to regulatory guidance and standards of practice, NPs, as primary care providers, are the opportune providers for completing universal screening and implementing BNIs and referrals to treatment. They have direct contact with a large group of patients who need to be screened and provided interventions as appropriate. Moreover, contact with patients allows NPs to implement preventive measures to avoid the development of comorbid conditions and other associated issues.

Integration of SBIRT into the MSN-NP curriculum as described in this article effectively facilitated students’ learning of SBIRT. The use of a scaffolding approach across the multiple courses and clinical practica provided repeated exposure to the content, thus facilitating retention. In addition, the use of varied
modes of teaching, such as lectures, simulation, case studies, and role-playing, further enhanced student learning. Finally, the incorporation of SBIRT into clinical practice allowed students to apply their knowledge and skills with patients.

Because students had opportunities to implement SBIRT in multiple clinical practica, many were able to use SBIRT numerous times. In addition, even if students encountered barriers in one clinical practicum, they had opportunities to use SBIRT in their other clinical practica. The results of clinical data for the first cohort indicated the majority of the students used screening and BNIs in their clinical practica. Overall, the scaffolding approach in both the curriculum and clinical practica with the varied teaching modes facilitated the students’ competence.

Other factors that promoted student learning were faculty competence and preceptor training. Faculty needed to be knowledgeable about SBIRT and proficient in skills such as motivational interviewing. Intense training of faculty with follow-up evaluations and observations of teaching sessions validated faculty competence. Clinical preceptors needed to be trained so that students in their practice settings would be guided by preceptors with the same knowledge base. In addition, preceptors needed to be aware that the MSN program had incorporated SBIRT into the curriculum so that the preceptors would provide opportunities for students to use SBIRT in the clinical setting. Although training NPs in SBIRT is critical, it is also crucial that the training be effective through the use of innovative and varied methods, and inclusive of preceptors.

REFERENCES


