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The Alcohol and Other Drugs Education Program for Social Work Faculty: A Model for Immersion Training

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NEED FOR ALCOHOL AND OTHER DRUGS-RELATED KNOWLEDGE AND CLINICAL SKILLS

The Prevalence of AOD Use and Its Consequences

AOD use is widespread and constitutes a critically important social and public health problem impacting individuals, families, and communities across the United States (US) (Salas-Wright, Vaughn, & Reingle Gonzalez, 2016). Millions of Americans consume alcohol on a regular basis and large-scale epidemiologic evidence indicates that nearly three in ten (28%) American adults regularly exceed the safe drinking limits outlined by the National Institute on Alcohol Abuse and Alcoholism (NIAAA; US Department of Health and Human Services [DHHS], 2016). This is noteworthy given the overwhelming evidence that at-risk or heavy drinking can result in a plethora of adverse outcomes including: serious physical injury due to motor vehicle accidents, falls, drowning, and other trauma (Hingson,

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Publisher's Disclaimer: This article presents the Alcohol and Other Drugs Education Program (ADEP) as a model for faculty training in evidence-based alcohol and other drug (AOD) identification and treatment. We make the case that AOD use is a serious social and public health issue and highlight faculty training as a strategic approach for addressing the pressing demand for clinical professionals who can provide AOD-related services. In turn, we describe the core elements of ADEP, including the program's foundational assumptions and logic, guiding principles and design, and situate ADEP within the context of other efforts to improve the quality of AOD-related clinical care.

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Zha, & Weitzman, 2009); interpersonal violence and violent victimization (Salas-Wright, Reingle Gonzalez, Vaughn, Schwartz, & Jetelina, 2016; Salas-Wright, Hernandez, Maynard, Saltzman,& Vaughn, 2014); and health conditions such as liver disease, pancreatitis, high blood pressure, heart disease, cancer, depression, and alcohol use disorder (Grant et al., 2015 Rehm et al., 2006, 2009). Moreover, recent evidence demonstrating meaningful increases in the prevalence of alcohol use, at-risk drinking, and alcohol use disorder in the United States suggests that our nation's problems with drinking are unlikely to attenuate without sustained effort (Dawson, Goldstein, Saha, & Grant, 2015; Grant et al., 2017).

While alcohol is the most commonly used drug of abuse in the United States, the use of illicit drugs and the misuse of a variety of prescribed controlled substances—including opioid-based pain medications—constitute major social and public health problems. For example, recent estimates indicate that 13% of American adults use marijuana annually (Compton, Han, Jones, Blanco, & Hughes, 2016) and nearly one in three (31%) past-year users has a marijuana use disorder (Hasin et al., 2015). Importantly, the prevalence of adult marijuana use appears to be on the rise with significant increases observed among college students, young adults, and middle-aged and older adults (Salas-Wright et al., 2017; Salas-Wright, Vaughn, Todic, Córdova, & Perron, 2015; Schulenburg et al., 2017). In light of these figures—as well as research on the impact of marijuana use on brain development, school performance and lifetime achievement, and a number of health conditions—leading voices in addiction science have been careful to counter the popular notion that marijuana use is a "harmless pleasure" (Volkow, Baler, Compton, & Weiss, 2014). Beyond marijuana use, national data suggests that the use of other illicit drugs and illicit drug use disorders in general are surprisingly common and frequently co-occur with serious behavioral and psychiatric problems (DeLisi, Vaughn, Salas-Wright, & Jennings, 2015; Grant et al., 2016). Recent years have, of course, witnessed the manifold consequences of the nation's opioid epidemic, including steep increases opioid-related social and healthcare costs, incarceration, and overdose mortality (Dart et al., 2015; Florence, Zhou, Luo, & Xu, 2016; Rudd, Aleshire, Zibbell, & Matthew Gladden, 2016).

Simply, national evidence makes plain that AOD use is disconcertingly common and that the consequences of AOD are far-reaching, including problems such as unintentional injury, violent victimization, and serious illness. For those with AOD use disorders, trajectories of use can span decades and, regretfully, often result in profound damage in the lives of those who use and the people around them (Hser, Longshore, & Anglin, 2007). Leading voices in social work are correct in identifying AOD use as a "grand challenge" that demands the attention of those committed to improving the health and welfare of the nation (Begun et al., 2016).

Working with Individuals Experiencing AOD-Related Problems

Professional social work practice invariably touches upon AOD use and its consequences. As stated by the National Association of Social Workers ([NASW] 2013) in the *NASW Standards for Social Work Practice with Clients with Substance Use Disorders*, Social workers regularly encounter individuals, families, and communities affected by substance use disorders (SUDs). Many social workers specialize in the alcohol, tobacco, and other

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drugs field, whereas others provide services to individuals and their families in specialty and non-specialty settings in which SUDs are often integral to the clients' presenting problems. (p. 5).

This statement is consistent with evidence indicating that more than seven in ten (71%) NASW members carry out one or more tasks related to AOD screening and/or treatment annually, and that more than 25% of social work clients have either a primary or secondary AOD use disorder (Smith, Whitaker & Weismiller, 2006). Interestingly, Smith and colleagues (2006) also found that, despite the fact that AOD-related work is common in clinical practice, very few social workers (2%) identify "addictions" as a primary area of practice. This combination of findings suggest that, not only are many social workers doing AOD-related work, but the overwhelming majority are doing so as non-specialty practice outside of a formal treatment facility.

The research by Smith and colleagues (2006) focused on clinical practice with individuals experiencing problems related to their own AOD use. However, we know that AOD impacts not only AOD users, but also the lives of people around those who struggle with AOD use disorders. Indeed, support groups held daily across the nation—like Al-Anon and Nar-Anon—are specifically designed to provide support to those who experience significant stress as a result of a family member's alcoholism or drug addiction (Timko et al., 2013). We know that AOD use is related to involvement in a number of behaviors that negatively impact others, including child abuse and neglect (Semidei, Radel, & Nolan, 2001), driving automobiles or operating machinery while intoxicated (National Highway Traffic Safety Administration, 2015), and involvement in violent and antisocial behavior (Vaughn, Salas-Wright, & Reingle Gonzalez, 2016). Taken from this vantage point, it is clear that virtually all social workers will encounter individuals impacted directly by AOD use or by connections with AOD using individuals. Even social workers who are not in the field of AOD treatment, but who serve in roles such as hospital social workers, child-protective workers, mental health clinicians and school social workers, are likely to have many clients and families with needs associated with AOD use disorders. In sum, we can state with confidence that to be a social worker is to work with individuals—often on a daily basis—whose lives are affected by AOD use and AOD-related problems.

Not Enough Social Workers are Prepared to Address AOD-Related Problems

Despite the fact that the majority of social workers regularly work with individuals impacted by AOD use, there is compelling evidence that social work clinicians are simply not well equipped to address AOD-related problems effectively. Indeed, findings from a growing body of research suggest that many social workers report feeling underprepared to engage with clients who have AOD use disorders, largely due to a lack of AOD-related knowledge and advanced training (Bina et al., 2008; Galvani, Dance, & Hutchison, 2012; Galvani & Hughes, 2010; Hutchison, Galvani, & Dance, 2013). Recent evidence suggests that, compared to alcohol and drug counselors, social work clinicians receive far less instruction in AOD and report a greater need for continuing education in AOD use disorder screening and treatment (Fisher, McCleary, Dimock, & Rohovit, 2014). Notably, the observed deficiencies in AOD-related clinical skills and knowledge are not limited to generalist social

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work practitioners. In a study of social workers employed in AOD treatment facilities, Hall and colleagues (2000) found that many addiction-specialty clinicians are also in need of additional training, with a majority expressing a need for continuing education in AOD treatment.

And yet, the demand for social workers to carry out empirically-supported AOD screening, assessment, brief intervention, and treatment is rapidly increasing. Recent years have seen the passage of major health legislation—including the Mental Health Parity and Addiction Equality Act of 2008 and the Patient Protection and Affordable Care Act of 2010—that has greatly expanded access to treatment for AOD use disorders (Institute of Medicine[1], 2015). With greater access to care, there is an increased need for licensed clinical professionals to provide AOD-related services. Under managed care systems, insurance companies increasingly are providing for reimbursement of social workers as a less costly alternative to psychiatrists and psychologists. As a result, AOD-focused social workers are among the fastest-growing occupational groups in the United States with projections for continued growth expected well into the future (Bureau of Labor Statistics, 2016; Dohm & Shniper, 2007). Notably, this escalating demand is happening at the same time as prominent health-related institutions and federal agencies—including the Institute of Medicine/Health and Medicine Division (HDM), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and Substance Abuse and Mental Health Services Administration (SAMHSA)—have increasingly emphasized that empirically-supported interventions need to be prioritized in the delivery of AOD-related screening and treatment services. Thus, not only is there an increased demand for social workers who can fill AOD-related positions, but more than ever, there is a need for social work professionals skilled in empirically-supported AOD identification and treatment methods.

TRAINING FACULTY IN AOD-RELATED CONTENT

AOD-Related Content is Insufficiently Integrated in Social Work Education

Faced with a critical shortage of AOD-focused social work professionals, we view training social work faculty in empirically-supported AOD identification and treatment methods as a strategic approach for closing the growing workforce gap. Several recent studies suggest that AOD-related content is not sufficiently integrated into social work curricula and faculty instruction. Wilkey and colleagues (2013) found, in a review of Council on Social Work Education (CSWE) accredited Master of Social Work (MSW) programs, that only a handful (5%) of MSW programs require that students take a course in AOD/addiction. Moreover, Wilkey and colleagues found that only 14% of MSW programs offer specialization/concentration or certificate programs in AOD/addiction and one in three programs nationwide (36%) are without even a single elective course in this area. These findings are consistent with those of Russet and Williams (2015) who found—in a review of 89 Bachelor of Social Work (BSW) and 58 MSW programs across the United States—that only a fraction (BSW = 3%, MSW = 2%) required students take a course in AOD/addiction and the majority of BSW programs (55%) and more than one third of MSW programs (36%) failed

[1]The Institute of Medicine has been renamed the Health and Medicine Division (HDM) in the National Academies of Sciences, Engineering, and Medicine as of March 15, 2016.

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to offer an elective AOD/addiction course. These findings are particularly noteworthy in light of prior research suggesting that exposure to AOD coursework results not only in greater knowledge and preparedness, but also in more positive attitudes toward individuals with AOD-related problems (Bina et al., 2008; Senreich & Straussner, 2013).

Beyond options for coursework or specialization, two articles in this Special Issue also suggest that many social work faculty are without sufficient training to teach about AOD effectively (see Lundgren *el al.*, 2018) and often fail to cover AOD-related content (see Krull et al., 2018). Lundgren and colleagues found that—prior to the receipt of intensive AOD training—many clinical social work faculty evidence a lack of basic knowledge about AOD screening and diagnosis, medication-assisted treatment, and recovery and relapse prevention. Correspondingly, only a minority of faculty reported high levels of confidence in teaching about AOD-related topics in general (32%) or teaching about evidence-based AOD-related clinical skills (19%). Along the same lines, Krull and colleagues found that AOD-related content is covered only superficially in social work instruction in an array of key life course, social environmental, and health related content areas. Taken together, the findings from these studies suggest that, not only is AOD coursework insufficiently integrated into the required and elective social work curriculum, but faculty are often unprepared to integrate such content into their teaching.

AOD Training As Evidence-Based and Rooted in Social Context

The training of social workers must be rooted in a scientific understanding of AOD use disorders as biopsychosocial phenomena with strong neurobiological and genetic components (Salas-Wright et al., 2016), and must focus on evidence-based approaches to AOD identification and treatment, including: screening and brief intervention (Babor et al., 2007), medication-assisted treatment (Roman, Abraham & Knudsen, 2011), individual and group-based interventions (Córdova, Alers-Rojas, Perron, Salas-Wright, & Vaughn, 2017; Miller, Zweben, & Johnson, 2005), and relapse prevention (Marlatt & George, 1984). To be sure, it may not be possible to cover all of these topics sufficiently in anything but a semester long course; nevertheless, we as social work educators have a responsibility, at the very least, to *introduce* students to the fundamentals of the biopsychosocial nature of AOD use disorders and evidence-based AOD identification and treatment.

Consistent with the tenets of social work education and a person-in-environment approach (Hutchison, 2017), the training of social workers in AOD must underscore the ways in which AOD and AOD use disorders can only be fully understood within a broader context. State-of-the-art neurobiologic and intervention research are critical to advancing the treatment of AOD use disorders, but we also know—from high-quality, scientific research and our own experience as practitioners—that factors such as community and social context, client access to services, and racial/ethnic disparities cannot be ignored in understanding AOD (Guerrero, Warsh, Khackikian, Amaro, & Vega, 2013; Sprague Martinez et al., 2018). Along these lines, we see the importance of carefully adapting AOD treatment approaches to the cultural and social contexts of those in need (Marsiglia & Booth, 2015; Robles, Maynard, Salas-Wright, & Todic, 2016).

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Although social workers may be particularly attuned to the importance of social context in relation to AOD, such thinking is not unique to our profession. Indeed, the former director of the National Institute on Drug Abuse (NIDA), Alan Leshner (1997), in his seminal piece arguing for the importance of neurobiology in understanding AOD use disorders, was unequivocal in stating,

Addiction… is a brain disease for which the social context in which it has both developed and is expressed are critically

important… Not only must the underlying brain disease be treated, but the behavioral and social cue components must also be addressed (p. 46).

Similar sentiments have been expressed by Nora Volkow (the current director of NIDA) and George Koob (the current director of NIAAA) (Volkow, Koob, & McLellan, 2016). Simply, there is broad consensus that state-of-the-art AOD identification and treatment methods require that practitioners pay careful attention to the importance of the social environment.

THE ALCOHOL AND OTHER DRUGS EDUCATION PROGRAM (ADEP): AN ADAPTATION OF MEDICAL TRAINING PROGRAM FOR SOCIAL WORK EDUCATORS

The ADEP program is based on the template of the Chief Resident Immersion Training (CRIT) program that has provided Addiction Medicine training for physician educators for more than a decade (Alford et al., 2009). CRIT was initially developed by national experts in physician and other clinician AOD education—including members of the ADEP investigator and education team—and gradually modified based on participant evaluation and evaluator-led focus groups. The CRIT program is implemented over the course of four days and includes curriculum focused on: the basic principles of AOD use disorders and addiction; screening, assessment, and brief intervention; inpatient/outpatient management of alcohol and opioid use disorders; the misuse of prescribed controlled substances; the use of specific AODs, including marijuana, stimulants, and sedatives; and medical complications related to AOD use. Core program activities include a keynote address, didactic presentations with case examples, small group skill practice, group discussions, attendance at a meeting of a 12-step program, and informal conversations with individuals in recovery. CRIT participation has been shown to yield increases in AOD knowledge, confidence, and preparedness to teach clinical skills (Alford et al., 2009).

In adapting the CRIT model to focus on clinical social work faculty, many of the basic curricular foci and pedagogical activities remained intact. However, we were careful in our initial adaptation and ongoing modifications—based on participant feedback from the inaugural ADEP program—to place a greater emphasis on the influence of social and contextual factors as well as disparities in AOD use, service access, and AOD-related risk factors. Moreover, the ADEP program was adapted to focus on didactic and activity-based content that could be integrated into a variety of foundational and advance practice social work courses, or into an AOD-focused elective or required course.

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Primary Assumptions and Program Logic

The ADEP program is rooted in two primary assumptions that, in turn, relate to our program design, activities, and outcomes (see Table 1). The *first assumption* is that empirically-supported AOD identification and treatment methods are not sufficiently taught in schools of social work due, in part, to a lack of knowledge and training among social work faculty. As described above, this assumption is supported by ample evidence indicating that social workers are not currently receiving sufficient training in AOD identification and treatment (Bina et al., 2008; Fisher et al., 2014; Galvani et al., 2012; Galvani & Hughes, 2010; Hutchison et al., 2013; Russet & Williams, 2015; Wilkey et al., 2013). This assumption is also consistent with research published in this Special Issue suggesting that—prior to immersion training—ADEP participants report only superficially covering AOD-related content in their teaching in an array of core social work content areas and that this lack of integration is related to a lack of faculty knowledge, confidence, and expertise (Krull et al., 2018; Lundgren et al., 2018).

The program's *second assumption* is that training social work faculty to teach AOD identification and treatment methods will lead to increased faculty knowledge and teaching efficacy and, in turn, increased student knowledge and skill in AOD identification and treatment. This assumption is substantiated by findings from CRIT and other programs that provide compelling results that intensive training with educators can, in fact, result in meaningful increases in knowledge and teaching efficacy (Alford et al., 2009; Amodeo & Litchfield, 1999; Walsh, Hooven, & Kronick, 2013). This assumption is further substantiated by findings—published in this Special Issue—suggesting that ADEP participation resulted in sizable increases in AOD knowledge and teaching confidence (Lundgren et al., 2018). That being said, these findings should be tempered by research suggesting that self-assessments of learning and efficacy do not invariably translate into measurable improvements in practice (Mathieson, Barnfield, & Beumont, 2009; Miller & Mount, 2001). As such, the degree to which faculty training will result in increased knowledge and clinical skill among social work students remains an important empirical question (one we are striving to answer).

These foundational assumptions inform the logic framework of the ADEP program. Specifically, we have assembled a team of investigators, consultants, and clinical educators with the expertise to educate social work faculty in AOD identification and treatment methods. Below we describe the programmatic components, content-related modules, and outcome evaluation in greater detail. However, the basic logic is quite straightforward: there is a lack of AOD-related instruction in social work education that is a function of deficits in faculty knowledge and teaching confidence, and our program is designed to increase knowledge and confidence and to evaluate these increases among faculty and, in turn, among social work students.

Guiding Principles

The ADEP program is rooted in a number of guiding principles that draw from state-of-the-art epidemiologic, neurobiologic and genetic, and clinical research on AOD use disorders. The overall design of the program, the selection of core themes, the integration of content

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into particular modules, and the evaluation of participant learning was carried out with the intention of providing participants with multiple opportunities for exposure to these core insights. These guiding principles are the following:

1. *AOD use disorders are best understood as health conditions with biopsychosocial causes and consequences*. Addiction—or, in the language of DSM-5, severe substance use disorders—often manifests as a chronic, relapsing health condition. We are critical of moral or character-based models of AOD use disorders and embrace the language and logic of health and public health.
2. *Social-environmental factors are critical in understanding AOD risk, prevention, and treatment*. Such factors include the importance of: social determinants and racial- and ethnicity-based disparities; family, neighborhood, social, and cultural context; and client access to services. (see Sprague Martinez et al., 2018, in this Special Issue for an in-depth review)
3. *AOD identification and treatment methods must be rooted in scientific research*. There are a number of empirically-tested, valid and reliable screening and assessment instruments, as well as medical and psychosocial treatments. There are also many promising new approaches.
4. *A number of medication-related treatments for AOD use disorders have been rigorously tested and have been shown to be valid and effective*. Evidence suggests that such medication-related treatments are most effective when used in combination with psychosocial treatment modalities.
5. *There are important barriers to treatment seeking and recovery*. Key barriers include stigma, a shortage of well-trained AOD-focused clinicians, and the general lack of understanding of the nature and treatment of addiction.
6. *We need an integrated care model that focuses on the interrelated biological, psychological, and social aspects of AOD*. AOD use disorders are complex biopsychosocial conditions that demand multifaceted solutions.
7. *Social workers are critical members of integrated teams, and are well positioned to take on leadership roles*. Social workers are trained in multiple domains that relate to integrated behavioral health, including: the biopsychosocial and person-in-environment perspectives; relationship building and long-term client contact; and the importance of health equity and the social determinants of health.

These guiding principles are presented to ADEP program participants at the outset and conclusion of the immersion program, and are touched on throughout the program by faculty presenters and the ADEP program leadership.

Program Basics and Design

Immersion Training and Beyond—Consistent with the CRIT program, ADEP is primarily oriented around an intensive, on-site immersion training experience. Such an immersion-based program was deemed to be the optimal approach for a number of reasons. First, we wanted a training design that would bring together faculty from social work

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programs across the country in a face-to-face setting to promote collaboration in learning. This sort of direct contact—be it in a small group discussion or over one of the many shared meals—builds connections between faculty and creates a shared sense of community that can inspire new ideas and practices, and motivate faculty in efforts to improve their teaching. Additionally, taking faculty out of their day-to-day professional commitments over the period of four days helps them focus their attention on improving knowledge and pedagogical skill.

To be sure, while the immersion training experience is the centerpiece of the ADEP program, it is by no means the entire program. Rather, the immersion component launches faculty as they return home to integrate new AOD content into their classrooms, revise syllabi and, in some cases, develop specialized AOD-focused courses. Indeed, toward the end of the immersion experience, faculty participants are expected to outline a teaching and curriculum integration plan that is to be integrated during the following academic year (see Salas-Wright and colleagues [2018] in this Special Issue for examples of teaching/curriculum integration). Subsequently, participants are contacted via email and telephone by members of the ADEP team to discuss their progress. Faculty participants are also encouraged to communicate and share resources directly with other participants via a secure online portal/community. Beginning at the 2018 Society for Social Work and Research 22nd Annual Conference, we will also sponsor informal gatherings with ADEP participants/alumni in order to foster a continued connection with the program and share examples of faculty innovations in integrating AOD content.

Training Modules and Activities—The ADEP program includes a combination of didactic presentations, small and full group discussions, clinical skills practice sessions, training in pedagogical methods, and field visits to AOD treatment settings. As shown in Table 2, Module 1, which begins the immersion program, covers critical *background* information designed to welcome and orient participants around the basic goals of the program (i.e., advance student learning in empirically-supported AOD identification and treatment methods), and to emphasize the importance of disparities in behavioral health and the centrality of contextualized services and social justice. Next, Module 2 provides additional background information related to the nature and course of AOD use disorders as well as the basics of AOD use disorder diagnosis. Subsequently, the program shifts to emphasize empirically-supported *AOD identification and treatment methods*, including: medical and medication-assisted treatment for AOD (Module 3); screening, assessment, and brief intervention, including motivational interviewing (Modules 4–5); assessment and treatment of co-occurring disorders (Module 6); psychosocial treatments (Module 7), and relapse prevention (Module 8). All of the aforementioned modules focused on identification and treatment methods include a mix of case examples, dyadic exercises, and skill building sessions. We also arrange for participants to attend an open meeting of a 12-step program and, later, reflect on the experience of attending the meeting in group discussions with the ADEP team.

Having laid a foundation of AOD-related knowledge and clinical skills, the immersion program shifts to a focus on *pedagogy and teaching* (Module 9). As part of this critical component of the immersion program, faculty review and discuss effective strategies for

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teaching AOD content and begin outlining their teaching and curriculum integration plans that will be implemented over the following academic year. We are careful to communicate from the very beginning of the immersion program that ADEP is fundamentally a program focused on educating educators who will, in turn, utilize the insights gleaned from the training not only for their own clinical practice, but also in their ongoing education of social workers. This message is also communicated to all faculty presenters as they prepare to lead their didactic and clinical skills practice sessions. In short, while one particular module is specifically dedicated to pedagogy, the entire immersion training is—at its core—about pedagogy and increasing the knowledge, teaching confidence, and preparedness of social work educators.

Finally, the program returns to the importance of *social context*. Specifically, Module 10 is rooted in an eco-developmental framework (Szapocznik & Coatsworth, 1999), underscoring the importance of family systems in AOD use and recovery and providing an overview of family-based approaches to AOD treatment. Cognizant of the widespread impact of trauma and its relation to AOD use disorders, Module 11 provides an in-depth review of the importance of trauma and victimization in the etiology of AOD use disorder as well as the importance of trauma-informed practice in AOD identification and treatment. As part of our emphasis on social context, we also travel to a community-based agency that emphasizes culture and the cultural adaptation of evidence-based practices. The program closes with a session entitled, “Moving Forward: Culture, Context, and Social Justice,” emphasizing social work’s commitment to vulnerable and oppressed populations (NASW, 2008) and reflecting on the relevance of this commitment to the prevention, identification, and treatment of AOD-related problems.

Evaluation of Outcomes—Consistent with the emphasis in ADEP on the importance of scientific research, we have designed our program in a way that allows for rigorous evaluation. As previously described, the ADEP program is designed to yield increases in faculty AOD knowledge, teaching confidence, preparedness, content integration and, ultimately, increased AOD learning among social work students. All faculty participants are asked to complete a *web-based assessment* prior to the initiation of the ADEP program with follow-up assessments at the conclusion of the immersion program and at 6-months and 12-months post-immersion training. The web-based assessments include a number of true/false and multiple-choice questions tapping AOD-related knowledge as well as self-assessments of AOD-related teaching confidence, preparedness, and content integration. In addition to collecting data from faculty participants, we will collect longitudinal data for a comparison sample of clinical social work faculty from across the United States. More information on the assessment battery—including pre- and post-test results from the 2017 cohort—is provided elsewhere in this Special Issue (Krull et al., 2018; Lundgren et al., 2018).

Beyond survey assessments, we also will collect *qualitative* data at 6-months and 12-months following participation in the ADEP program. The qualitative assessments will include a brief interview (via phone) regarding the integration of AOD-related content into social work instruction, a brief written document summarizing the ways in which ADEP participation led to pedagogical or curriculum innovations, and any challenges faced in attempting to integrate AOD-related content. We will also gather information from *students of ADEP*

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faculty participants, to assess the degree to which faculty participation in the immersion program and, in turn, increases in faculty knowledge, confidence and preparedness, and content integration resulted in increased student knowledge and clinical skills. Specifically, a subset of ADEP faculty participants and faculty in the comparison sample (i.e., clinical faculty who have not participated in the ADEP program) will be randomly selected; students enrolled in a course taught by these faculty will complete an assessment of AOD-related knowledge at the outset and the conclusion of the course. Taken together, all of the aforementioned evaluation components are designed to provide a rich, in-depth assessment of the ways in which faculty and students are impacted by the ADEP program.

THE ROAD AHEAD

In June 2017, the first cohort of social work faculty (N = 50) participated in the ADEP program held at Boston University, in Massachusetts. Preliminary findings presented in this Special Issue provide compelling evidence that faculty participation resulted in substantial gains in AOD-related knowledge and teaching confidence. Our evaluation will continue as we monitor faculty content integration and curricular innovation, and assess the degree to which social work students are impacted by faculty participation in ADEP. We have begun recruitment for a second cohort of faculty (N = 50) who will participate in the ADEP program in June 2018 at the University of Denver in the shadow of the Rocky Mountains, in Colorado.

To be certain, we are well aware that our program is part of a broader effort to improve the quality of social work instruction in AOD use disorder identification and treatment, and to advance the skill development of social workers. Such efforts include programs designed to provide social work faculty with ready-made materials for teaching on an array of AOD-related topics (Begun, 2005), to stimulate interest in AOD-related training and research among future social work practitioners and educators (Truncali et al., 2012), and to train students and professional social workers in topics such as motivational interviewing (Hohman, 2015), Screening, Brief Intervention, and Referral to Treatment (Carlson et al., 2017; Sacco et al., 2017; Putney, O'Brien, Collin, Levine, 2017; Senreich, Ogden, & Greenberg, 2017), harm reduction (Estreet, Archibald, Tirmazi, Goodman, & Cudjoe, 2017) and other AOD identification and treatment methods (McNeece & DiNitto, 2011).

We are well positioned to make a unique contribution to this larger effort. Specifically, our goal is to develop a cadre of social work faculty who are knowledgeable about AOD use disorders and have the confidence and preparedness to educate the next generation of social workers. While other programs target students directly or provide valuable online resources, our program is unique in its focus on immersion training for the faculty that are actively working to educate the next generation of helping professionals. We are well aware that the ADEP program is not currently able to meet the training needs of all social work faculty in the US[2] and that many schools of social work may not be able to offer such an intensive program. As we pursue additional funding and forge collaborations with social work faculty

[2]As detailed above, we trained 50 full time faculty in 2017 and are in the process of recruiting the same number of faculty for participation in 2018. Our hope is to increase the number of social work faculty trained annually in the near future in order to make this program available to a greater number of faculty in the United States.

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nationwide, we hope to make immersion training available to a far greater number of social work faculty. Our task is to ensure that social work students in the 21st century benefit from educators who are knowledgeable about AOD and well prepared to give students the evidence-based skills needed to work effectively with the millions of Americans who struggle with AOD-related problems.

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Table 1

Alcohol and Other Drugs Education Program (ADEP) Logic Model

Assumptions	Input	Activity/Output	Outcomes
Empirically-supported alcohol and other drug (AOD) identification and treatment methods not taught in graduate schools of social work due to social work faculty lack of knowledge and training.	ADEP Leadership and Evaluation Team: • L. Lundgren (PI) • C.P. Salas-Wright (PI) • D.P. Alford (Co-I) • I. Krull (Coordinator) • M. Amodeo (Consultant).	4-day intensive immersion training program for full-time social work faculty.	Participants' knowledge of empirically-supported AOD identification and treatment and self-efficacy in teaching about these issues.
Training faculty to teach AOD identification and treatment methods and integrate into the curriculum will increase faculty knowledge and teaching efficacy as well as student knowledge.	Faculty presenters with expertise in AOD identification and treatment, and pedagogy for adult learners.	Implementation of 1 year teaching and curriculum integration plan for each ADEP participant	Participants' inclusion of timely and accurate content and materials on AOD identification and treatment in the curriculum of their schools
	Research assistants to support overall program logistics (e.g., food, transportation) and collection of evaluation data.	Collection and analysis of mixed methods evaluation data.	Social work students' knowledge on empirically based AOD identification and treatment by those students who participated in the ADEP participants' courses.

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Table 2

Program Schedule and Training Modules

DAY 1	**Introduction to the Program** • **Overview and Welcome** • **Keynote address:** *Social Context and Disparities in Behavioral Health* **Module 1: Social Work's Role in Alcohol and other Drug (AOD) Work** Social work's role in: integrated care, screening, assessment, increasing client readiness for change, intervening with family members, using principles of AOD treatment and empirically-supported identification and treatment practices, and increasing the readiness of social service agencies to respond to AOD issues, with emphasis on social context and social justice.
	Module 2: Nature and Course of AOD Including Opioid Use Disorder • AOD neurobiology • Genes and the brain • AOD continuum • Life course perspective on AOD • DSM 5 diagnostic criteria • Drug categories and their different effects
	Module 3: Medical Treatment for AOD • Medications for AOD disorders • Medications for alcohol • Medications for opioid use • Detoxification process • Other biological interventions for AOD conditions.
DAY 2	**Module 4: Screening, Assessment, and Interviewing** • Screening and assessment tasks • Steps in SBIRT; common pitfalls; key guidelines • Differences in screening, assessment, and drug type **Skill Practice Session:** Screening, assessing, and interviewing
	Module 5: Stages of Change; Motivational Interviewing and AOD Use Disorders • Assessing readiness; providing feedback to clients; negotiating a plan • Motivational interviewing as a philosophy • Principles of motivational interviewing **Skill Practice Session:** Assessing readiness to change and practicing MI skills with individuals with AOD use.
	Module 6: Co-occurring AOD Use Disorders and Psychiatric Disorders Assessment • Assessment methods; determining independence of conditions for co-occurring conditions and use of drug (e.g., Alcohol, Opioids) • Common co-occurring conditions including PTSD **AA/NA visits in the evening:** Attend in small groups, travel with RAs/facilitators.
DAY 3	**Module 7: Summary of Evidence, Empirically-supported Psychosocial Treatments** • Discussion of learning experiences from AA/NA meetings • Principles of AOD treatment • Research registries of AOD-related empirically, supported evidence-based treatment practices and methods for evaluating the research.

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	• Overview of treatments important to social workers including: Cognitive-Behavioral Therapy, Relapse Prevention, Integrated Dual-diagnosis Treatment, Assertive Community Treatment, Multidimensional Family Therapy, Contingency Management, and trauma interventions (e.g., Seeking Safety, TREM), intensive case-management and other case management models, supportive housing. • Review of systematic reviews on EBPs inclusion and testing on different population groups, nationally and globally.
	Module 8: Early Recovery and Preventing Relapse • Understanding AOD disorders as relapsing conditions • The science behind relapse • Models of relapse prevention • Helping clients manage cravings and urges **Skill Practice Session:** Identifying relapse triggers, teaching clients refusal skills, discussing post-acute withdrawal Participant discussion
	Module 9: Teaching Pedagogy: Integration of Content on Causes, Consequences of Addiction, SBIRT, MI, and Relapse Prevention in the Clinical Core Practice Curriculum • Teaching strategies about AOD, screening, assessment and relapse prevention. • Facilitators/ barriers for including the content we covered so far in core curriculum • Teaching strategies for AOD and using screening, MI and relapse prevention techniques.
	Module 10: Family Treatment • Evidence-based treatments for families—What does the research tell us? What role can social workers play? • Women and children. • Medications and Neonatal Abstinence Syndrome. • Project Bright, an example of a promising social work intervention to promote child-wellbeing in opioid dependent families.
DAY 4	**Module 11: Trauma-specific and Trauma-informed Treatments** Field visit at local agency which provides culturally specific, integrated health and behavioral health treatment for Latinos. • Specific treatments for clients with PTSD • Guidelines for trauma work with clients with AOD use disorders • How to provide culturally relevant behavioral health and medical treatment. • Trauma-informed practice—what should social service agencies know and do in working with these clients? • Talking to clients in recovery
	Moving Forward: Culture, Context, and Social Justice • Focus on social work's commitment to vulnerable and oppressed populations • Relevance of social justice to prevention, identification, and treatment of AOD-related problems. • Discussion of project and of activities in the coming year