

2021

Screening, Brief Intervention and Referral to Treatment (SBIRT) Training with Counselor Education Students

Tiffany Lee

Western Michigan University, tiffany.lee@wmich.edu

Stephen E. Craig

Western Michigan University, stephen.craig@wmich.edu

Andrew Clay

Western Michigan University, andrew.d.clay@wmich.edu

Karis Callaway

Western Michigan University, karislaine.callaway@wmich.edu

Diana Charnley

Western Michigan University, diana.m.charnley@wmich.edu

Follow this and additional works at: <https://repository.wcsu.edu/jcps>



Part of the [Counselor Education Commons](#)

Recommended Citation

Lee, T., Craig, S. E., Clay, A., Callaway, K., & Charnley, D. (2021). Screening, Brief Intervention and Referral to Treatment (SBIRT) Training with Counselor Education Students. *The Journal of Counselor Preparation and Supervision*, 14(2). Retrieved from <https://repository.wcsu.edu/jcps/vol14/iss2/10>

Screening, Brief Intervention and Referral to Treatment (SBIRT) Training with Counselor Education Students

Abstract

Counselors should be proficient in screening for problematic substance use and also demonstrate the ability to provide a brief intervention, when appropriate. As part of a three-year grant project, counselor educators at one institution provided intensive training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) to clinical mental health counseling students. This SBIRT protocol is designed to promote early detection and effective intervention for clients at risk of developing a substance use disorder. The purpose of this article is to present an in-depth narrative related to the process, content, and pedagogical methods of the training. The authors also address the lessons learned throughout the experience and provide recommendations to core faculty that may plan on incorporating SBIRT into curriculum.

Keywords

counselor training, substance abuse, SBIRT

Author's Notes

Acknowledgement is given to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funding this project, grant number 6H79TI025960-03M002, and Denise Bowen, a co-principal investigator, for her contribution related to the grant activities.

A significant portion of the United States population will use alcohol and other drugs (AOD) in their lifetime. In fact, an estimated 216 million Americans, aged 12 and older, have used alcohol in their lifetime and 118 million have used marijuana (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Although use may not always be problematic, research suggests that many Americans also engage in risky patterns of consumption. Each month, almost one-fourth (24.2 percent) of adults (aged 12 and older) binge drink, one out of 10 (10.6 percent) use an illicit substance, and 8.9 percent use some form of marijuana (SAMHSA, 2017). Moreover, opioid-related deaths have more than doubled for men and quadrupled for women since 1999 (SAMHSA, 2017). Research indicates that many people seeking mental health services often have risky substance use patterns as well, indicating the potential for the presence of co-occurring disorders with clients in a counseling setting. For example, about 35 million U.S. adults received mental health services in 2016, and of the 8.2 million people with co-occurring mental health and substance use disorders, less than half (3.9 million) received treatment (Park-Lee et al., 2017). These statistics highlight the importance of screening for problematic substance use in all mental health settings (Park-Lee et al., 2017).

Due to prevalence of use and the potential for co-occurring disorders, the identification of problematic AOD use among clients seeking mental health counseling is imperative. Once identified, methods for addressing these behaviors must be skillfully employed by mental health counselors (MHCs). Traditionally, AOD interventions (by medical and mental health providers) have been focused on those who have severe use patterns or meet the criteria for a substance use disorder (SUD), as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013). More recently, the protocol suggested for health care professionals is Screening, Brief Intervention, and Referral to Treatment (SBIRT),

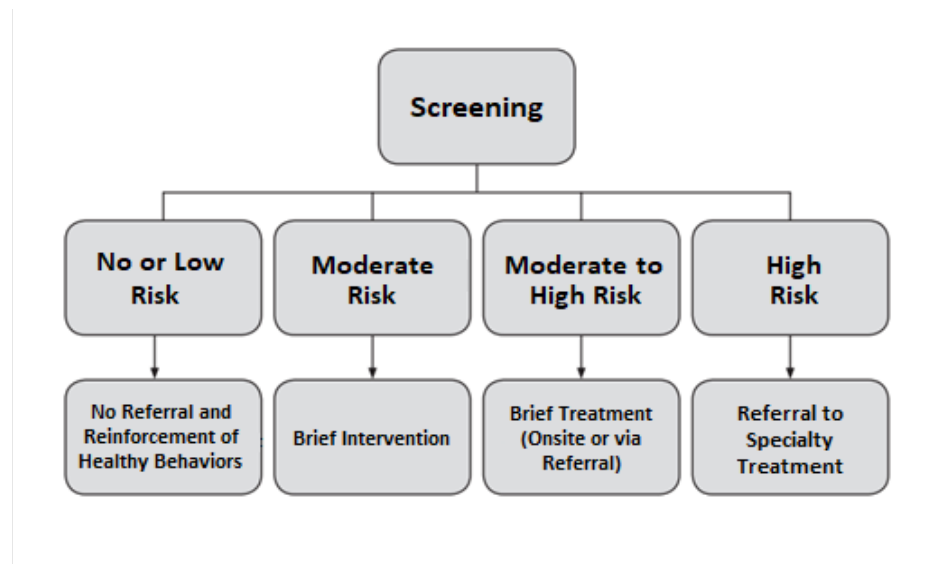
which aims to provide effective strategies for early intervention *before* the risky use warrants specialized treatment (SAMHSA, 2013).

SBIRT Protocol

The first part of the SBIRT process is screening and it does not provide results that identify the type of problem occurring or its severity. Instead, a screening score indicates whether a problem exists and if further assessment is needed (SAMHSA, 2013). One of the key aspects of screening that SAMHSA recommends is that it should be conducted using a validated psychometric instrument (e.g., the Alcohol Use Disorders Identification Test [AUDIT], Drug Abuse Screening Test [DAST], etc.) and last no more than 10 minutes (SAMHSA, 2013). The screening results allow professionals to initiate conversations with clients about their use while employing Motivational Interviewing (MI) to facilitate healthy behavior change. Depending on the screening tool used, clients are assigned a risk level based on their reported use patterns. For example, the AUDIT classifies alcohol use into one of four zones with a corresponding risk. People endorsing little or no risky AOD behavior may not need an intervention but may still benefit from reinforcement and encouragement of their healthy behaviors. Clients endorsing substance use patterns of moderate risk are provided a brief intervention, while those indicating high risk use patterns may need either a brief treatment or further diagnostic assessment and a referral to more intensive specialty treatment (SAMHSA, 2013; see Figure 1).

Figure 1

SBIRT Process Determined by Risk Level



Note: Adapted from SAMHSA (2013) with permission.

Over the past decade, researchers have found SBIRT to be effective in a variety of settings and therefore, advocate for its continued use (Curtis et al., 2014; Vaca et al., 2011). For instance, a meta-analysis of randomized clinical trials confirmed the utility of SBIRT in reducing harmful drinking with adults in primary care settings (Solberg et al., 2008). Another study found a 68 percent reduction in illicit drug use over a six-month period by individuals who received SBIRT services. Among those who reported heavy drinking at baseline, the rate of heavy alcohol use was almost 39 percent lower at six-month follow-up (Madras et al., 2009). SBIRT has also been linked to improvements in other psychosocial aspects including fewer arrests and emotional problems, and more stability related to housing, employment status, and overall health (Madras et al., 2009).

While SBIRT is garnering positive results and increasing utility nationwide, some issues still exist surrounding the inconsistency of its use, and professionals' lack of knowledge and confidence in utilizing SBIRT. DiClemente et al. (2015) have also identified concerns associated

with the fidelity of its implementation. When investigators studied the occurrence of screening in primary care with adolescents, they determined fewer than 50 percent of pediatricians screen adolescents for substance use. Among those who do screen, only 16 percent used a standardized instrument (Harris et al., 2012). Not only is SBIRT under-utilized, but there is also an absence of awareness by school-based health professionals related to screening and intervention. In 2016, approximately one-third of administrators and two-thirds of clinicians and health care workers in a school-based health center were unaware of SBIRT and its benefits (Harris et al., 2016). Further, 75 percent of those participants reported having the ability to help prevent sexually transmitted infections and pregnancy, but only about 25 percent indicated being effective at helping students reduce substance use. In addition, if clinicians did screen for substance use, less than half (47 percent) reportedly used a standardized tool (increasing the likelihood that students with risky use were not getting identified) in their health center (Harris et al., 2016).

Since 2003, SAMHSA has set forth several initiatives to address the deficiency in knowledge and skills regarding substance use screening and intervention among health professionals. Historically, funding opportunities were available to train medical residents in SBIRT; however, there has been a recent shift to include students in other health-related fields including MHCs. Between 2013 and 2016, SAMHSA awarded 75 SBIRT training grants; researchers from Western Michigan University (WMU) were among this group who received funding for a 3-year project from 2015-2018. The WMU project focused on incorporating SBIRT into the curriculum of two academic departments, the Department of Counselor Education and Counseling Psychology (CECP) and the Department of Physician Assistant. The content of this article is specific to the training with the CECP students. The reasons for choosing the CECP students were twofold: (1) research substantiates a lack of addiction training among counseling

programs nationwide (Lee & Bischof, 2015), and (2) the Council for Accreditation of Counseling and Related Educational Programs (CACREP) specifically mandates training in this area for all students (Section 2.F.3.d., CACREP, 2016; Lee et al., 2013).

There is a dearth of literature available to faculty members who wish to provide SBIRT training to counselors. A review of the available SBIRT literature published over the last decade reveals numerous articles highlighting survey results from student SBIRT trainings. More specifically, researchers have published student outcomes related to training satisfaction, knowledge acquisition, perceived competence, and perceived usefulness of the training in nursing (Puskar et al., 2013; Mitchell et al., 2017), medical residency (Clemence et al., 2016; Kalu et al., 2016), and social work (Carlson et al., 2017; Sacco et al., 2017). A minimal number of articles providing detailed curriculum information and delivery methodologies were identified, all of which were quantitative in nature (Bray et al., 2014; Scott et al., 2012; Senreich et al., 2017). Some authors have written brief descriptions of their methods for providing the training but focused on the survey results rather than specifying details on what content was taught and the delivery methods used. Moreover, publications related to evaluation strategies (i.e., formal coding instruments) for SBIRT skill-based activities (e.g., roleplays) are limited and primarily present empirical support for these instruments as opposed to a description of the curricular implementation. In short, no article has been identified by the current authors that outlines best practices for training MHCs in SBIRT. Thus, the main purpose of this article is to present an in-depth narrative related to the process, content, and pedagogical methods implemented at one institution as a means for their faculty to address the CACREP CMHC program addiction-related standards. While the primary aim is to disseminate information related to these aspects of SBIRT

implementation, the authors also provide results gathered from a student satisfaction survey, which SAMHSA required as part of the grant reporting process.

SBIRT Training with CMHC Students

The *SBIRT Training with Students and Community Organizations in the Health Professions in West Michigan* was a \$526,192 three-year SAMHSA grant project awarded in 2015. Over a two-year period, 199 health professionals in the community and 131 master's-level students from WMU were trained in SBIRT. Thirty-two of the 131 students were from the CECP Department. The student trainees participated in classroom didactic instruction, an online module, a video recorded roleplay, and a feedback session based on a formal evaluation of the roleplay. The first two authors of this article were the Project Director/Principal Investigator and Co-Principal Investigator, respectively, and were responsible for creating and delivering the trainings in the classroom. These investigators also developed and provided oversight of the other components of the training, such as the experiential roleplays with a standardized client. The third and fourth authors were doctoral associates at the time of the grant and extensively involved with the experiential activities. The associates assisted in the roleplay experiences, completed the evaluations of the video recorded roleplays with standardized clients, and met with each student participating in the one-on-one feedback sessions. The next section begins by denoting the decision-making process related to choosing the best course for embedding SBIRT into the CMHC curriculum. Then, the reader is provided with a detailed description of the (a) knowledge-based curriculum, including the classroom didactic and online instruction and (b) skill-based curriculum, including the roleplays and feedback sessions.

Choosing a Course

The SBIRT curriculum was initially incorporated into one of the two graduate-level addictions courses required of CMHC students based upon its fit with the established learning objectives. Building upon what was strictly knowledge-based instruction regarding substance screening and assessment and MI, the SBIRT curriculum integrated both knowledge and skill-based training in each domain of SBIRT. In order to reach more CMHC students, the training was also implemented in one section of Counseling Practicum, of which the second author was instructor-of record. The differences between the training experiences in these two courses are discussed below.

Knowledge-Based Training

The didactic portion of the training occurred first, with four total hours of content delivered over two class periods. The first half focused on the following: (a) understanding the various components of SBIRT and how substance use impacts mental and physical health (e.g., co-occurring disorders); (b) alcohol education (what is considered “one drink” and risky drinking patterns); (c) how to identify and use empirically-based screening tools and be familiar with the DSM-5 criteria for SUDs; (d) understanding when a brief intervention should occur and the components of MI, identifying the stages of change (Miller & Rollnick, 2004), and learning how to employ a pocket guide, which included the Readiness Ruler (Heather et al., 2008); and (e) when and how to refer to treatment and the importance of a “warm handoff,” when possible (Khan et al., 2018). The focus of the second lecture was the introduction of an evaluation tool, the Proficiency Checklist (PC) (Pringle et al., 2017). The students used the PC to evaluate video demonstrations of SBIRT by clinical professionals, as well as experiential roleplays with their classmates. A more in-depth description of the PC and its utility in the training is provided in the next section.

All students were provided 3-ring binders containing the presentation materials, including information on MI, change talk, various illicit drugs, a few screening instruments, and a list of resources in the community (e.g., 12 step meetings; food assistance; and medical, mental health, and substance use treatment providers). Students also received their own 3x5 pocket guide and educational tool to utilize during their classroom and video recorded roleplays as well as with future clients. The SBIRT student training curriculum and binder materials are free to view and download from the WMU SBIRT website (<https://wmich.edu/addictionstudies/sbirt>).

Online Training

The course chosen for the SBIRT training was a hybrid format and thus, it allowed for the inclusion of web-based instruction as a component of the student learning experience. The education was delivered through video observations, peer-to-peer discussion board interactions, reflection exercises, and a quiz. Two online discussion threads were directly related to SBIRT training. The first discussion was generated for further learning after students had viewed a short video on the core concepts of SBIRT. The main prompt of this thread focused on complex reflections and student's self-perception on their implementation ability. The second discussion followed student's engagement with a brief case presentation and AUDIT scores. The students were then required to generate possible open-ended questions and explain the significance of these questions to their conceptualization of the client's experience.

Additionally, students viewed two videos illustrating brief negotiation (an interviewing process rooted in MI that is frequently utilized in medical settings) and composed a three- to five-page reflection paper. The purpose of this paper was to further familiarize students with the similarities of MI and brief negotiations, solidify evaluative abilities of when to refer a client to further treatment, and promote awareness of diversity variables during their SBIRT

implementation. The quiz was comprised of 15 randomly selected multiple-choice questions. These questions tested one's knowledge of the foundational facets of SBIRT such as risk identification, screening tool use, MI skills, and referral procedures. By adopting this multi-modal approach to instruction and assessment, the online training component facilitated the development and demonstration of the knowledge, skill, and professional disposition required to competently implement SBIRT.

Skill-Based

The CACREP standards were devised with a recognition that knowledge alone is insufficient for counselor preparation. Therefore, various iterations of the standards over the years have included knowledge *and* skills-based components. In this section, the authors first describe the two instruments that were used to measure “fidelity” (DiClemente et al., 2015, p. 219) to the SBIRT protocol. Next, an overview of the SBIRT training and preparation of the doctoral associates is given. Last, the authors elucidate the various experiential and supervisory methods that were implemented to foster SBIRT skill development in MHC students.

Instrumentation

Following an extensive review of the literature and considering the current developmental stages of the counselors-in-training, the team selected two instruments to utilize for the trainings, the PC (Pringle et al., 2017) and the MD3 SBIRT Coding Scale (DiClemente et al., 2015). Both measures were used to facilitate student learning to ensure “fidelity” (DiClemente et al., 2015, p. 219) to the SBIRT protocol. The PC assesses the presence or absence of SBIRT components while the MD3 Scale provides a more detailed evaluation and quantifiable score of the counselor's adherence to SBIRT. These two instruments were used to evaluate SBIRT implementation during the practice roleplays in the classroom and videotaped roleplays. The authors' intent was not to

gather pre- and post-test data for publication. Therefore, the discussion of these two instruments focuses on the utility of these measures for student learning purposes.

Proficiency Checklist. The PC was created by Pringle et al. (2017) to assess the presence or absence of specific skills within five core domains of SBIRT: Screening, Brief Intervention, Referral to Treatment, Follow-up, and Motivational Interviewing spirit. The PC was developed by asking experts to rank 137 SBIRT skills on parsimony, ease of use, pertinence, fairness, applicability, clarity, comprehensiveness, and concreteness, which resulted in refining the list to 22 discrete skills that were used to create two different PCs. The initial iteration included all 22 items rated with Likert scales but was reduced to a shorter checklist where all 13 items are rated as present or not present (Pringle et al., 2017). For the study that resulted in the 13-item PC, a group of 13 medical school affiliated preceptors were asked to view six SBIRT delivery video simulations. Pringle et al. (2017) assessed interrater reliability by looking at overall agreement between preceptors yielding a moderate Fleiss' kappa of .42 ($p < .001$), which reinforced the previous results from a review of SBIRT assessment tools (Reho et al., 2016).

MD3 SBIRT Coding Scale. The MD3 Scale was developed to assess the skill level of those delivering SBIRT. DiClemente et al. (2015) coded 14 SBIRT-adherent behaviors with a three-point Likert scale (0 = behavior is absent; 1 = behavior is present or attempted, but is sparingly or insufficiently demonstrated; 2 = behavior is present and meets or exceeds the expectations of good SBIRT delivery). Seven SBIRT-nonadherent behaviors are assessed with frequency counts for each time a behavior is observed. Additionally, counselor-client collaboration and empathy are evaluated using a five-point Likert scale and are considered as “global rankings” (DiClemente et al., 2015). An overall score can be derived by subtracting the total number of nonadherent behaviors from the total adherent behaviors score. In the 2015 study, reliability was

assessed through interrater reliability using five advanced graduate students with motivational interviewing knowledge paired into three discrete coding groups, each of which reviewed five to 10 recordings of SBIRT delivery and independently scored them using the MD3 Scale. Using a two-way random model intraclass correlation coefficient (ICC), interrater reliability was found to be high ($> .75$) for all three subscales. The ICC for adherent behaviors = .95, nonadherent behaviors = .87, and the global ratings = .85. Additionally, DiClemente et al. (2015) noted that most individual items' ICC was greater than .60. The reliability of the MD3 Scale was also reinforced in a review of the several SBIRT assessment tools (Reho et al., 2016). The study by DiClemente et al. (2015) served as the basis for the way the present authors prepared the doctoral associates and measured the presence or absence *and* overall “fidelity” (DiClemente et al., 2015, p. 219) to the SBIRT delivery among the MHC students.

Training of Doctoral Associates

The in-class experiential roleplays and feedback sessions were conducted by two doctoral-level associates who were enrolled in Counselor Education and Clinical Psychology programs respectively. Prior to joining the study, both doctoral associates had previous training in providing BIs to clients and were deemed proficient in utilizing MI with diverse adult populations. As well, both had experience in offering clinical supervision to other students and community mental health providers.

Team Training

All authors were similarly trained in the PC and the MD3 Scale. Each was required to familiarize themselves with the individual measures by reviewing their available peer-reviewed literature (e.g., DiClemente et al., 2015; Pringle et al., 2012), validation study reports (e.g., Pringle et al., 2014), individual questions, and rating scales. For the MD3 Scale, the implementation guide

was also independently studied and then discussed as a group to encourage consensus in rating (DiClemente et al., 2015). Various PC training videos and completed checklist samples were also viewed by each author. Once a comprehensive understanding of the PC was established, two pre-selected videos were watched and rated independently by each team member. These independent ratings were then reviewed to evaluate interrater reliability.

Classroom Experiential Roleplays

In addition to the didactic training, all students engaged in experiential roleplays and were evaluated on their SBIRT skill development. This facet of the in-class training involved triadic group work during which students completed three distinct 10-minute roleplays, followed by 5-minutes of peer feedback. Students rotated through three unique roles: client, clinician, and observer. One of the trainers was also present in each group to observe and provide feedback.

For the mock client role, students were provided a PowerPoint slide with the basic biographical information and presenting concerns of the individual they were portraying. Students were also given a pre-completed AUDIT by the mock client and encouraged to utilize the pocket guide and educational handouts to assist in their responses during the roleplay. Students in the client role were urged to develop additional biographical detail as needed, which required the clinician to utilize SBIRT skills to obtain the information (e.g., beliefs about substance use, perceived effects of substance use) necessary to successfully implement SBIRT.

In the role of counselor, students were encouraged to reference the provided mock client information as they implemented SBIRT during the roleplay. They were allowed to review a blank PC to assist with their skill implementation as the goal of this experiential component was not to test the student's memory of the skills identified on the PC, but instead to allow them the opportunity to develop and practice the SBIRT skills effectively. During the roleplays, the student

clinician was encouraged to ask for assistance or technique clarification as needed from the observing partner or one of the trainers.

As the role of observer, the third student silently monitored the skill demonstration of the clinician and completed a PC. Upon completion of the roleplay, the observing student was responsible for leading the feedback discussion regarding the SBIRT skills demonstrated. During the peer feedback portion of this experience, the doctoral associates checked in with each group to answer SBIRT or MI questions, reiterate and demonstrate MI techniques, and to troubleshoot issues not previously discussed or understood from the didactic training element.

Video Recorded Roleplay and Feedback Sessions

After completing the in-class learning experience, students were provided a new standardized client scenario and completed AUDIT. They were afforded a brief review period and then completed a video recorded roleplay with a standardized client to be assessed for SBIRT adherent skills. The students entered the “counseling room” with the completed AUDIT, educational tool handout, and pocket guide to reference when engaging in SBIRT. To encourage a realistic interaction, the standardized clients consisted of either trained clinical actors from WMU’s Homer Stryker School of Medicine or a doctoral student in Counselor Education with significant experience in clinical roleplaying. Uniformity of student experience across actors was facilitated by actor adherence to a predetermined, detailed client profile which included co-occurring alcohol use and major depressive disorder.

To enhance the feedback process, video recorded participant roleplays were assessed by the two trained doctoral associates (the third and fourth authors) utilizing both the PC and MD3 Scale. In line with the recommendations put forth in the MD3 Screening, Brief Intervention, and Referral to Treatment Coding Scale Guide, each recording was viewed multiple times (DiClemente

et al., 2015). Prior to coding participant behaviors, the doctoral associates observed each roleplay in full for contextual understanding. After this initial review, recordings were then watched subsequent times to complete the respective assessment tools.

After evaluation of the video recordings using the PC and MD3 Scale were completed, roleplay review sessions occurred between the student and the doctoral associate who reviewed their video recording. Before receiving feedback, students were provided with copies of their scored PC and MD3 Scale so they could review their scores and written feedback beforehand. At the outset of each twenty- to thirty- minute review session, students were asked if they had any initial questions or points of clarification. After addressing these inquiries, the doctoral associates then facilitated a discussion of the findings noted on the PC. This tool was discussed with participants first because of its binary “Present” and “Not Present” assessment of SBIRT application and because of the students’ familiarity with it.

Scaffolding upon this discussion, the doctoral associates then addressed the more nuanced scores and comments made on the MD3 Scale. As students were not provided with MD3 Scale information at any point in their previous training, a concise yet detailed explanation of the measure was offered. The MD3 Scale afforded an opportunity for the doctoral associates to differentiate between presence and effective SBIRT application, and to provide examples from the student’s video recording. Additionally, the MD3 Scale offered the doctoral associates a chance to review and discuss non-adherent SBIRT behaviors (e.g., lecturing, premature diagnoses, and establishing goal/agenda without client input).

Through the MD3 Scale evaluation, the doctoral associates were also able to give students global feedback regarding demonstrations of collaboration and empathy. These two traits are specifically defined by the creators of the MD3 Scale and identified as critical to the effective

implementation of MI (Moyers et al., 2016). After discussing the MD3 Scale results and addressing any further questions, students were then provided access to their recorded roleplay and encouraged to further review their session with the evaluated PC and MD3 Scale to note areas of effectiveness and growth. They were then invited to send any potential follow-up questions to the training team. Refer to Appendix A for the learning objectives and examples of the SBIRT content delivered during each phase of the training.

Student Satisfaction Survey Results

The main purpose of this article is to present information on the process, content, and pedagogical methods implemented for the SBIRT training at WMU. To support the utility of the information provided, the authors also believe it is important to present the results from one of the grant surveys. As a SAMHSA-funded grant project, the Center for Substance Abuse Treatment (CSAT) satisfaction survey was required for governmental reporting purposes and the questions could not be altered (see Appendix B). The survey included 17 questions (rated on a Likert Scale) and was completed in the classroom at the end of the training. Of the 32 potential participants, 25 provided informed consent. There was a total of 22 participants that had useable data to analyze. The majority of students responded that they were “*Very Satisfied*” or “*Satisfied*” for most of the questions (see Table 1). To highlight, 95.46% of the students indicated (a) the training enhanced their SBIRT skills, (b) the information from the instructor was very useful, and (c) they would recommend the training to a colleague. While positive results were found, the authors identified a few areas for improvement and have recommendations for future research.

Table 1.*SBIRT Training Satisfaction Outcomes from CSAT Survey*

	N	Very Satisfied n (%)	Satisfied n (%)	Neutral n (%)	Dissatisfied n (%)	Very Dissatisfied n (%)
S_Q1	22	14 (63.64%)	6 (27.27%)	2 (9.09%)	0 (0%)	0 (0%)
S_Q2	22	18 (81.82%)	3 (13.64%)	1 (4.55%)	0 (0%)	0 (0%)
S_Q3	22	14 (63.64%)	5 (22.73%)	3 (13.64%)	0 (0%)	0 (0%)
S_Q4	22	14 (63.64%)	6 (27.27%)	2 (9.09%)	0 (0%)	0 (0%)
		Strongly Agree n (%)	Agree n (%)	Neutral n (%)	Disagree n (%)	Strongly Disagree n (%)
S_Q5	22	13 (59.09%)	8 (36.36%)	1 (4.55%)	0 (0%)	0 (0%)
S_Q6	22	17 (77.27%)	5 (22.73%)	0 (0%)	0 (0%)	0 (0%)
S_Q7	22	20 (90.91%)	2 (9.09%)	0 (0%)	0 (0%)	0 (0%)
S_Q8	22	19 (86.36%)	3 (13.64)	0 (0%)	0 (0%)	0 (0%)
S_Q9	22	20 (90.91%)	2 (9.09%)	0 (0%)	0 (0%)	0 (0%)
S_Q10	22	2 (9.09%)	9 (40.91%)	9 (40.91%)	2 (9.09)	0 (0%)
S_Q11	22	11 (50%)	10 (45.45%)	1 (4.55%)	0 (0%)	0 (0%)
S_Q12	22	17 (77.27%)	4 (18.18%)	1 (4.55%)	0 (0%)	0 (0%)
S_Q13	22	15 (68.18%)	6 (27.27%)	1 (4.55)	0 (0%)	0 (0%)
S_Q14	22	15 (68.18%)	6 (27.27%)	1 (4.55%)	0 (0%)	0 (0%)
S_Q15	22	21 (95.45%)	1 (4.55%)	0 (0%)	0 (0%)	0 (0%)
S_Q16	22	18 (81.82%)	3 (13.64%)	1 (4.55%)	0 (0%)	0 (0%)
		Very Useful n (%)	Useful n (%)	Neutral n (%)	Useless n (%)	NA n (%)
S_Q17	22	18 (81.82%)	3 (13.64%)	1 (4.55%)	0 (0%)	0 (0%)

Note: N is the available sample size used in the analysis out of a total of 25 subjects.

Lessons Learned in SBIRT Training with CMHC Students and Recommendations for

Future Research

Exciting developments are occurring with the use of SBIRT by MHCs, yet the methods for preparing counselors-in-training in the knowledge and skills necessary to deliver the approach competently are still in their infancy. This article presented a method of SBIRT training for MHCs that was employed by one group of researchers at a large, public research university in the upper Midwest. The training, while promising in its preliminary outcomes, is new and thus has provided the authors with valuable information on how it could be enhanced for future use.

The focus of this article is on the training program itself and not an evaluation of the program's effectiveness; however, the authors concede that further study of the training program's efficacy in producing desired learning outcomes would significantly strengthen the program and the confidence that educators could place in its content and method of delivery. Despite this needed improvement, those who may wish to implement the training should know that the program was blind, peer-reviewed and evaluated by experts a priori and deemed worthy of a 3-year research and training grant from SAMHSA. Following is a brief discussion of the lessons learned in this grant-funded project as well as some suggestions for future research.

Lessons Learned

The SBIRT training was well received by student participants, as evidence in their post-training feedback, yet there are seven key areas where the authors believe the training could be enhanced: (1) Curriculum implementation; (2) Adherence to time-limits on the video role-plays; (3) Greater attention to diversity aspects; (4) Use of practitioners who are utilizing SBIRT currently; (5) Use of actors for immediate feedback; (6) Use of the PC and MD3 Scale; and (7) Multiple rounds of formal feedback.

Curriculum Implementation

Counselor educators who ascribe to a developmental approach to their teaching and supervision of counselors-in-training must not only carefully consider the content but also the timing of its delivery to students (Loganbill et al., 1982; McAuliffe, 2011; Stoltenberg et al., 1998). For this training, the authors embedded the material in a course that has few pre-requisites and thus consisted of students with highly variable experiences. With the implementation of SBIRT, it is assumed that people attempting to adhere to its protocol will have basic counseling skills (e.g., empathy, reflective listening, timely use of open-ended questions, and use of immediacy).

Therefore, subsequent training experiences should include students who are far enough along in their program to implement the approach with fidelity to its original intent. For example, it may be more appropriate to include the didactic portions of the training in a course for which counseling techniques are a pre-requisite; then, the second phase of training could be addressed as part of a counseling practicum. Using the practicum as a place for the experiential roleplays (and perhaps application with real clients) ensures (a) appropriate levels of prior training in techniques, (b) the presence of close supervision of the counselor-in-training, and (c) opportunities to record sessions, with client permission, for use in supervision.

Time Limits on Experiential Roleplays

Another area for improvement rests in the time allotted for students to demonstrate SBIRT in the video-recorded roleplays. Originally, students were instructed to participate in a 15-minute roleplay with the trained actor. As the role-plays unfolded, many of the students struggled to demonstrate all facets of SBIRT within the 15-minute time frame and thus were permitted to extend the time as needed. Choosing not to rigidly adhere to time limits may have resulted in a loss of focus of “sessions” and promoted a tendency for an interview to wander away from the original purpose. Limiting the roleplays to 15 minutes might result in a more focused display of SBIRT that is faithful to its original intent.

Increased Attention to Diversity Aspects

As counselor educators are charged with providing training experiences that reflect the racial and ethnic diversity of the populations with whom they will eventually work (CACREP, 2016), the authors used training videos and mock clients who reflected a diverse society. However, when moving to the experiential component that relied on the use of actors, there was a lack of exposure to actors from minority backgrounds. In future training experiences, the authors believe

that recruiting actors who reflect a racially and ethnically diverse population will only enhance students' readiness to work with an increasingly diverse society. For this training, the authors recruited from a group of actors who routinely play patient-roles for the university's medical school students/residents; pursuing a racially and ethnically diverse pool of volunteers would be a substantial improvement.

Practitioners Utilizing SBIRT Currently

One of the challenges in preparing students for the counseling profession is linking the theoretical and knowledge-based functions with the application in the real world. This reality is reflected in the CACREP standards (CACREP, 2016) where students must demonstrate both knowledge and skill during their training programs. In other words, knowledge alone does not imply skill. The authors of this training believe that inviting counselors from local agencies that utilize SBIRT on a consistent basis to serve as a panel during both the introductory and experiential phases of the training could be a helpful modification. During the introductory phases of the training, the panel could share about the importance for having an empirically supported approach to screening and intervening with people with problematic substance use. Few things resonate with students better than hearing from practitioners who are currently and consistently utilizing an approach they are presently learning. The panel could be invited to return during the experiential phase of training to discuss lessons they have learned from using SBIRT in practice, some recommendations for its successful implementation, and things to avoid in trying to execute the approach faithfully.

Use of Actors for Immediate Feedback

The actors themselves could also provide immediate feedback to students, a practice that is common in the medical school training milieu (E. Spaulding, personal communication, June 7,

2016). Such a modification would align with the benefits of formative evaluation commonly utilized in counselor supervision (Bernard & Goodyear, 2014, pp. 223-224). Formative evaluation, unlike summative which is focused on overall learning outcomes, is aimed at providing timely, specific feedback that counselors can implement in a subsequent learning experience.

Use of the PC and MD3 Scale

One intentional choice that was integral to the overall success of this training experience was the utilization of two widely accepted measures for assessing fidelity to the SBIRT approach. At the first phase of training, the authors utilized the PC believing it was the more developmentally appropriate tool at the outset of students' learning. Once students understood the basic elements of SBIRT and had opportunities to practice its implementation with peers doing experiential roleplays, the authors shifted to use of the MD3 Scale for the experiential roleplays with trained actors. The thought was that as students progressed with increasing knowledge and skill, the MD3 Scale would allow for students to learn from the feedback provided from a more detailed and nuanced measure. Furthermore, the MD3 Scale provides a quantitative score on a continuous scale that lends itself well to quantitative measuring of change. Although use of the PC at the beginning was a developmentally appropriate decision, the MD3 Scale provides a more robust and nuanced instrument that aids in the quantitative measurement of change. The authors concluded that incorporating the MD3 Scale sooner in the training experience and inviting students to complete their own self-evaluation of the recorded roleplays using both the PC *and* the MD3 Scale would further strengthen the overall training experience.

Multiple Rounds of Formal Feedback

Another way to improve subsequent training experiences would be to incorporate multiple rounds of formal feedback, when possible. This could first occur by having more formal feedback

during in-class roleplays. For the video-recorded roleplays, students could be encouraged or required to watch their sessions and to prepare specific questions for use in feedback sessions with their supervisors. Following the initial feedback session, students could then be provided with opportunities to apply what they have learned in additional sessions that are recorded. By providing multiple rounds of formal feedback and inviting students to watch their sessions before the feedback session, students are given the opportunity to identify their strengths and highlight key areas for improvement for subsequent trials that are also recorded.

Recommendations for Future Research

Despite the exciting expansion of SBIRT from the medical profession to the counseling profession, there is considerable work to be done in evaluating the approach's effectiveness when implemented by MHCs. Specifically, the methods by which MHCs are trained need further study. One of the key limitations of this article is a lack of a comprehensive program evaluation. Although not the focus of the current manuscript, results from a comprehensive program evaluation would be a significant follow-up contribution to the project described herein. There is a lack of empirical studies exploring the methods by which MHCs are trained in SBIRT and whether the trainings that do exist actually yield the intended outcomes for preparing counselors to skillfully screen, provide brief interventions, and refer for more extensive treatment. Such studies could measure the most developmentally opportune time for conducting such trainings and whether they produce demonstrable change in student proficiency over time.

As the mental health profession relies heavily on clinical supervision as a means for advancing knowledge and skill as students move into their post-graduate pursuit of licensure, it could prove helpful to better understand the role supervision plays in extending proficiency even after formal training may have ended. Studies that evaluate supervisor methods of evaluation of

competency, including further validation of instruments like the PC and MD3 Scale, could be a worthwhile contribution. Ultimately, the merit of any training resides in the evaluation of its outcomes and whether such trainings yield changes in knowledge and competency.

Conclusion

The importance of screening for problematic substance use is well-established in community mental health settings (Park-Lee et al., 2017). Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been suggested as the protocol of choice for health professionals who seek to reduce the risk of problematic substance use *before* the need for more specialized treatment options (SAMHSA, 2013). Researchers have already established the efficacy of SBIRT in primary medical practice and school-based clinics and thus recommend its continued use (Curtis et al., 2014; Vaca et al., 2011). There is currently a paucity of literature on *how* counselor educators can incorporate SBIRT training into their addictions-related training for MHCs and then how they might measure both knowledge and skill outcomes.

This article presented a method that one program utilized to train MHC students for this important, preventative work with the understanding that it may also prove useful in community mental health settings where the likelihood of encountering people with problematic substance use is substantial. The article also highlighted two established measures for assessing student learning, the PC and MD3 Scale. Not only must programs find ways to train counselors in SBIRT and incorporate SBIRT into existing curriculum, but they must also find ways to measure and document student learning outcomes to accrediting bodies.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th edition). American Psychiatric Publishing.
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th edition). Pearson.
- Bray, J. H., Kowalchuk, A., Waters, V., Allen, E., Laufman, L., & Shilling, E. H. (2014). Baylor pediatric SBIRT medical residency training program: Model description and evaluation. *Substance Abuse, 35*(4), 442-449. <https://doi.org/10.1080/08897077.2014.954026>
- Carlson, J. M., Schwindt, R., Agle, J., Gassman, R. A., Vannerson, J., & Crapp, D. (2017). Effects of training on social work, nursing and medical trainees' knowledge, attitudes and beliefs related to screening and brief intervention for alcohol use. *Journal of Alcohol and Drug Education, 61*(1), 14-35.
- Clemence, A., Balkoski, V., Schaefer, B., Lee, M., Bromley, N., Maisonneuve, I., Hamilton, C. J., Lukowitsky, M. R., Poston, J., Hall, S., Pieterse, P., Antonikowski, A. & Glick, S. (2016). Multispecialty screening, brief intervention, and referral to treatment (SBIRT) training in an academic medical center: Resident training experience across specialties. *Substance Abuse, 37*(2), 356. <https://doi.org/10.1080/08897077.2015.1082953>
- Council for Accreditation of Counseling and Related Educational Programs [CACREP]. (2016). *2016 standards for accreditation*. Author.
- Curtis, B. L., McLellan, A. T., & Gabellini, B. N. (2014). Translating SBIRT to public school settings: An initial test of feasibility. *Journal of Substance Abuse Treatment, 46*(1), 15-21. <https://doi.org/10.1016/j.jsat.2013.08.001>
- DiClemente, C. C., Crouch, T. B., Norwood, A. E. Q., Delahanty, J., & Welsh, C. (2015). Evaluating training of screening, brief intervention, and referral to treatment (SBIRT) for substance use: Reliability of the MD3 SBIRT coding scale. *Psychology of Addictive Behaviors, 29*(1), 218-224. <https://psycnet.apa.org/doi/10.1037/adb0000022>
- Harris, S. K., Herr-Zaya, K., Weinstein, Z., Whelton, K., Perfas, Jr., F., Castro-Donlan, C., Straus, J., Schoneman, K., Botticelli, M. & Levy, S. (2012). Results of a statewide survey of adolescent substance use screening rates and practices in primary care. *Substance Abuse, 33*(4), 321-326. <https://doi.org/10.1080/08897077.2011.645950>
- Harris, B. R., Shaw, B. A., Sherman, B. R., & Lawson, H. A. (2016). Screening, brief intervention, and referral to treatment for adolescents: Attitudes, perceptions, and practice of New York school-based health center providers. *Substance Abuse, 37*(1), 161-167. <https://doi.org/10.1080/08897077.2015.1015703>
- Heather, N., Smailes, D., & Cassidy, P. (2008). Development of a Readiness Ruler for use with alcohol brief interventions. *Drug and Alcohol Dependence, 98*(3), 235-240. <https://doi.org/10.1016/j.drugalcdep.2008.06.005>
- Kalu, N., Cain, G., Mclaurin-Jones, T., Scott, D., Kwagyan, J., Fassassi, C., Greene, W. & Taylor, R. E. (2016). Impact of a multicomponent screening, brief intervention, and referral to treatment (SBIRT) training curriculum on a medical residency program. *Substance Abuse, 37*(1), 242-247. <https://doi.org/10.1080/08897077.2015.1035841>
- Khan, M., Conte, J., Njoku-Anokam, A., Gordon, S., Abbate, M., Deprivil, J., Chan, S. & Rivera, A. (2018). Emergency department warm handoff program: Using peers to improve emergency department patient engagement and linkages to community-based substance

- use disorder services. *Annals of Emergency Medicine*, 72(4), S144. <https://doi.org/10.1016/j.annemergmed.2018.08.372>
- Lee, T. K., & Bischof, G. (2015). Addiction training in counselor education programs: A survey of the current status and future plans. In S. Southern & K. L. Hilton (Eds.), *Annual review of addictions and offender counseling II: Best practices* (pp. 41-65). Wipf and Stock Publishers.
- Lee, T. K., Craig, S. E., Fetherson, B. T. L., & Simpson, C. D. (2013). Addiction competencies in the 2009 CACREP clinical mental health counseling program standards. *Journal of Addictions & Offender Counseling*, 34(1), 2-15. <https://doi.org/10.1002/j.2161-1874.2013.00010.x>
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, 10(1), 3-42.
- Madras, B. K., Compton, W. M., Avula, D., Stegbaur, T., Stein, J. B., & Clark, H. W. (2009). Screening, brief interventions, and referral to treatment (SBIRT) for illicit drug and alcohol use at multiple health care sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence*, 99, 280-295. <https://doi.org/10.1016/j.drugalcdep.2008.08.003>
- McAuliffe, G. (2011). Deep learning: The work of Dewey, Kohlberg, and Kolb. In G. McAuliffe & K. Eriksen (Eds.), *Handbook of counselor preparation: Constructivist, Developmental, and Experiential approaches* (pp. 13-30). Sage.
- Miller, W. R., & Rollnick, S. (2004). Talking oneself into change: Motivational interviewing, stages of change, and therapeutic process. *Journal of Cognitive Psychotherapy*, 18(4), 299-308. <https://doi.org/10.1891/jcop.18.4.299.64003>
- Mitchell, A. M., Kane, I., Lindsay, D. L., Hagle, H., Puskar, K., Aiello, J., Boucek, L. & Knapp, E. (2017). Educating emergency department registered nurses (EDRNs) in screening, brief intervention, and referral to treatment (SBIRT): Changes in attitudes and knowledge over time. *International Emergency Nursing*, 33, 32-36. <https://doi.org/10.1016/j.ienj.2016.12.003>
- Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The Motivational Interviewing Treatment Integrity Code (MITI 4): Rationale, preliminary reliability and validity. *Journal of Substance Abuse Treatment*, 65, 36-42. <https://doi.org/10.1016/j.jsat.2016.01.001>
- Park-Lee, E., Lipari, R. N., Hedden, S. L., Kroutil, L. A., & Porter, J. D. (2017, September). Receipt of services for substance use and mental health issues among adults: Results from the 2016 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration [SAMHSA]. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016/NSDUH-DR-FFR2-2016.pdf>
- Pringle, J. L., Kowalchuk, A., Meyers, J. A., & Seale, J. P. (2012). Equipping residents to address alcohol and drug abuse: The national SBIRT residency training project. *Journal of Graduate Medical Education*, 4(1), 58-63. <https://doi.org/10.4300/JGME-D-11-00019.1>
- Pringle, J. L., Seale, J. P., & Bray, J. H. (2014, September). SBIRT Proficiency Checklist validation study. Retrieved from [https://www.indianasbirt.org/documents/Fidelity%20InstSBIRT%20Validation%20Study%20\(PERU,%202014\).pdf](https://www.indianasbirt.org/documents/Fidelity%20InstSBIRT%20Validation%20Study%20(PERU,%202014).pdf)
- Pringle, J. L., Seale, J. P., Shellenberger, S., Grasso, K. M., Kowalchuk, A., Laufman, L., Bray, J. H. & Aldridge, A. (2017). Development and evaluation of two instruments for assessing screening, brief intervention, and referral to treatment (SBIRT) competency. *Substance Abuse*, 38(1), 43-47. <https://doi.org/10.1080/08897077.2016.1152343>

- Puskar, K., Gotham, H. J., Terhorst, L., Hagle, H., Mitchell, A. M., Braxter, B., Fioravanti M., Kane, I., Talcott, K. S., Woomeer G. R. & Burns, H. K. (2013). Effects of screening, brief intervention, and referral to treatment (SBIRT) education and training on nursing students' attitudes toward working with patients who use alcohol and drugs. *Substance Abuse*, 34(2), 122-128. <https://doi.org/10.1080/08897077.2012.715621>
- Reho, K., Agle, J., DeSalle, M., & Gassman, R. (2016). Are we there yet? A review of screening, brief intervention, and referral to treatment (SBIRT) implementation fidelity tools and proficiency checklists. *The Journal of Primary Prevention*, 37(4), 377-388. <https://doi.org/10.1007/s10935-016-0431-x>
- Sacco, P., Ting, L., Crouch, T. B., Emery, L., Moreland, M., Bright, C., Frey, J. & DiClemente, C. (2017). SBIRT training in social work education: Evaluating change using standardized patient simulation. *Journal of Social Work Practice in the Addictions*, 17(1-2), 150-168. <https://doi.org/10.1080/1533256X.2017.1302886>
- Scott, D. M., McLaurin-Jones, T., Brown, F. D., Newton, R., Marshall, V. J., Kalu, N., Cain, G. E. & Taylor, R. E. (2012). Institutional incorporation of screening, brief intervention, and referral to treatment (SBIRT) in residency training: Achieving a sustainable curriculum. *Substance Abuse*, 33(3), 308-311. <https://doi.org/10.1080/08897077.2011.640135>
- Senreich, E., Ogden, L. P., & Greenberg, J. P. (2017). A postgraduation follow-up of social work students trained in "SBIRT": Rates of usage and perceptions of effectiveness. *Social Work in Health Care*, 56(5), 412-434. <https://doi.org/10.1080/00981389.2017.1290010>
- Solberg, L. I., Maciosek, M. V., & Edwards, N. M. (2008). Primary care intervention to reduce alcohol misuse: Ranking its health impact and cost effectiveness. *American Journal of Preventive Medicine*, 34(2), 143-152.e3. <https://doi.org/10.1016/j.amepre.2007.09.035>
- Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). IDM supervision: An integrated developmental model for supervising counselors and therapists. Jossey-Bass.
- Substance Abuse and Mental Health Services Administration (2013). *Systems-level implementation of screening, brief intervention, and referral to treatment. Technical assistance publication (TAP) series 33*. HHS Publication No. (SMA) 13-4741. Author.
- Substance Abuse and Mental Health Services Administration (2017). *2016 National Survey on Drug Use and Health: Detailed Tables*. Author.
- Vaca, F. E., Winn, D., Anderson, C. L., Kim, D., & Arcila, M. (2011). Six-Month follow-up of computerized alcohol screening, brief intervention, and referral to treatment in the emergency department. *Substance Abuse*, 32(3), 144-152. <https://doi.org/10.1080/08897077.2011.562743>

Appendix A

Learning Objectives and SBIRT Content for Student Training

Training Period	Objectives	Sample Content
Class 1 (2 hours)	<ul style="list-style-type: none"> • Understand the purpose of SBIRT and identify its components. • Recognize symptoms of physical and mental health disorders associated with substance use. • Define “one-drink,” drinking limits, drinking patterns for U.S. males, females, and older adults. • Identify empirically valid screening tools. • Describe Stages of Change. • Identify “Change Talk” and DARN-CAT. • Understand brief intervention and its difference from brief therapy and specialized treatment. • Describe motivational interviewing (MI), and its components. • Understand how to evoke meaning, collaborate in goal setting, and negotiate commitment. • Know community referral options. 	<ul style="list-style-type: none"> • Statistics of substance use prevalence, costs to society, and consequences of use. • Overview of SBIRT components. • SBIRT pocket guide and brief intervention tools, including readiness ruler. • Overview of AUDIT, DAST, CRAFFT, DSM-5. • Screening scores and determining the type of intervention warranted. • Four MI basic principles. • OARS – open ended questions, examples of affirmations, various types of reflections, how to summarize. • Readiness Ruler – importance, readiness, and confidence. • Feedback – content to give client (e.g., screening score) and process involved (e.g., ask permission to discuss answers on screening tool). • Continuum of care and warm-hand off.
Online Module (4 hours)	<ul style="list-style-type: none"> • Demonstrate knowledge of basic tenets of screening, MI, and referral processes. • Engage peers in written dialogue regarding the knowledge and skills needed to effectively implement SBIRT. • Reflect upon attitudes pertaining to SBIRT implementation and clients with problematic substance use. 	<ul style="list-style-type: none"> • Assessments (quiz, discussion posts, paper) utilized to gauge students’ SBIRT knowledge, skills and attitudes. • Feedback rubrics for assessments to facilitate understanding of strengths and limitations. • Use of hypothetical case study videos and online forum for peer-to-peer sharing.
Class 2 (2 hours)	<ul style="list-style-type: none"> • Know how to administer, score, and interpret scores for the AUDIT. • Know how to use Proficiency Checklist (PC) to evaluate others on use of SBIRT. • Apply the PC to evaluate peers’ SBIRT implementation. • Provide evaluative feedback to peers about their SBIRT implementation. • Demonstrate effective use of SBIRT. 	<ul style="list-style-type: none"> • Review of AUDIT. • Introduction of PC. • Use of AUDIT and PC with two video demonstrations. • Use of SBIRT in groups of 3 in class (i.e., counselor, client, and evaluator roles). • Videotaped roleplays with standardized client actor in a private room.
Feedback Session (1 hour)	<ul style="list-style-type: none"> • Discuss with their evaluator their skill-based SBIRT demonstration. • Identify strengths, areas for growth, and strategies for increasing efficacy. • Discuss potential barriers to future SBIRT implementation and possible resolutions. 	<ul style="list-style-type: none"> • Review PC and MD3 Scale scores of student video. • Reference course materials and handouts. • Roleplay effective implementation strategies.

Appendix B

List of CSAT Student Satisfaction Survey Questions

S_Q1: How satisfied are you with the overall quality of this training?

S_Q2: How satisfied are you with the quality of the instruction?

S_Q3: How satisfied are you with the quality of the training materials?

S_Q4: Overall, how satisfied are you with your training experience?

S_Q5: The training class was well organized.

S_Q6: The material presented in this class will be useful to me in dealing with substance abuse.

S_Q7: The instructor was knowledgeable about the subject matter.

S_Q8: The instructor was well prepared for the course.

S_Q9: The instructor was receptive to participant comments and questions.

S_Q10: I am currently effective when working in this topic area.

S_Q11: The training enhanced my skills in this topic area.

S_Q12: The training was relevant to my career.

S_Q13: I expect to use the information gained from this training.

S_Q14: I expect this training to benefit my clients.

S_Q15: This training was relevant to substance abuse treatment.

S_Q16: I would recommend this training to a colleague.

S_Q17: How useful was the information you received from the instructor?