

2022

Substance Use Disorders Expansion of Practitioner Education in Social Work: A Pilot Project

FINAL EVALUATION REPORT



COUNCIL ON SOCIAL WORK EDUCATION

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Abstract

This report describes a project undertaken by the Council on Social Work Education (CSWE) between the years 2019 and 2022 to integrate high-quality, standardized substance use content into social work core curricula. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) through a Practitioner Education grant, CSWE partnered with 32 schools of social work to develop and distribute curriculum resources in key content areas and related assessment tools addressing the CSWE core competencies. This report outlines the objectives of the pilot project, evaluation methods used, and the outcomes achieved.

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Overview

In 2020, 40.3 million people aged 12 or older (or 14.5%) met criteria for a substance use disorder (SUD) during the previous year, including 28.3 million individuals with an alcohol use disorder, 18.4 million people with an illicit drug use disorder, and 6.5 million individuals with both an alcohol use disorder and an illicit drug use disorder (Substance Abuse and Mental Health Services Administration, 2020). Although the impact of the COVID-19 pandemic that began in 2020 is still evolving, initial data suggest that widespread anxiety and isolation may have resulted in increased consumption of both alcohol and illicit substances during this time (Roberts et al., 2021). Social workers comprise one of the largest groups of professionals in the behavioral health workforce, and they encounter individuals with substance use disorders in a range of health, criminal justice, and social service settings (Heisler, 2018). As such, social workers have a key responsibility to screen, assess, and treat mental health and addiction concerns. However, significant gaps exist in the education of social workers on substance misuse, with many social work education programs having only a limited emphasis on addictions (Estreet et al., 2017) and only 2% offering a required course on addictions (Russett & Williams, 2015), resulting in a subsequent lack of knowledge, skills, and confidence (Senreich & Straussner, 2013).

From 2019 to 2022, the Council on Social Work Education (CSWE) received funding through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Practitioner Education program to address the lack of high-quality, standardized SUD curricula in accredited schools and programs of social work. This project, entitled "Substance Use Disorders Expansion of Practitioner Education in Social Work," aimed to strengthen the

preparation of future social work practitioners to deliver high-quality, evidence-based SUD prevention, treatment, and recovery services.

The objectives of the project were to

1. produce and distribute a standardized SUD curriculum to use with master of social work (MSW) students in accredited programs of social work,
2. increase the capacity of social work faculty to teach standardized SUD content,
3. increase the capacity of social work field instructors (intern supervisors) to enhance MSW interns' experiences with SUD,
4. enhance the social work field experience for MSW students in the area of SUD,
5. increase the number of MSW students enrolled in SUD-specific courses, and
6. increase social work students' knowledge and understanding of SUD and working with SUD clients.

This final evaluation report describes the methods undertaken to assess the effectiveness of the CSWE Practitioner Education pilot project and summarizes its key findings. It discusses the development of the outcome measures used as well as the incorporation of process data during the project to refine implementation.

Methods

Methods Overview

This new curriculum aligns with the social work competencies in CSWE's Educational Policy and Accreditation Standards, as well as the CSWE *Specialized Practice Curricular Guide for Substance Use Social Work Practice*, partially funded by the American Academy of Addiction Psychiatry as part of their Opioid Response Network grant. Guided by SAMHSA priorities and those needs identified by faculty participating in Year 1 of the pilot project, curricular resources were developed to address the following five key areas: theories of substance use; assessment; intervention; ethical and professional behavior; and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Training and technical assistance were provided by CSWE to participating social work programs throughout the project period, including monthly calls facilitated by CSWE staff for faculty of participating programs. Qualitative methods were used to collect process indicators such as barriers to implementation, faculty perception of feasibility, and additional resources that might be beneficial. Primary outcome measures collected were *reach* (number of students receiving the enhanced substance use curriculum) and *effectiveness* of the curriculum as indicated by student achievement of the nine CSWE core competencies.

Measures

Reach. CSWE had two overall objectives for the project's reach: to increase the preparedness of social work faculty to deliver substance use content and to increase the exposure

of MSW students to high-quality substance use content in both the classroom and the field settings. The following indicators were used to measure reach of the pilot project.

- *Number of faculty trained.* The number of participating social work programs in Year 1 and Year 2 who sent faculty liaisons to attend monthly trainings offered by CSWE.
- *Number of students receiving new curriculum.* The number of MSW students who received the newly developed curricular content in the context of classroom learning.
- *Number of students in specialized substance use practicums.* The number of MSW students whose field practicum site specialized in services related to substance use and misuse.
- *Number of students receiving substance use content in nonspecialized placements.* The number of students whose field practicum site did not specialize in substance use but where students spent a minimum of 25% of their time performing tasks related to services for substance use.

Effectiveness: achievement of core CSWE competencies for social work students. A grading rubric with an anchored, 5-point scale was used to assess student achievement of all nine CSWE competencies. Demonstration of competencies was elicited using a case study assignment created to assess student competency applied to substance use content (see Appendix A).

Development of Case Study Assessment

The primary outcomes assessment emerged out of a collaborative effort between CSWE and faculty from participating social work programs. With assistance from the evaluation consultant and the training consultant, faculty participants mapped curricular components to each

of the nine CSWE core competencies. Educational activities were identified to address each of the competencies. The training consultant then grouped and expanded this content into four curricular themes to be implemented in Year 1. These themes were as follows: theories of substance use; assessment; intervention; and Screening, Brief Intervention, and Referral to Treatment (SBIRT). One additional curricular theme was implemented in Year 2 based on feedback from faculty in participating programs (ethical and professional behavior).

Initially, the evaluation consultant proposed creating four assessments of student competency, with one aligned to each of the four curricular themes identified by the training consultant. Inclusion of the competencies identified for each theme along with each of the four dimensions of the competency (knowledge, cognitive and affective processes, values, and skills) at least once in the assessment was prioritized to generate detailed feedback on each curricular area. Strong consideration was also given to maximize flexibility for the pilot schools that will be integrating the assessments into their courses. Two sample competency assessments were created for review; these are described below.

The student competency assessment created for the curricular content, Theories of Substance Use, requested that students identify a special population (such as gender, race/ethnicity, and sexual orientation) and use a person-in-environment theory of substance use to describe what factors (1) promote or protect from engaging in substance misuse, (2) might affect help-seeking and engagement, and (3) support or hinder recovery. The assignment description was accompanied by a 5-point grading rubric for instructor use that addressed CSWE Competencies 1–9.

A second assessment tool was created to evaluate student competency with SBIRT. This two-part assessment included a 10-item multiple-choice pre- and posttest, along with a reflective

Objective Structured Clinical Examination–style assessment to be completed following a simulation exercise. A grading rubric for the student reflection was also created (see Appendix A).

After review, CSWE expressed a preference that assessment of competencies for each of the four curriculum modules be condensed into a single assessment tool to evaluate the new curriculum as a whole. CSWE selected the case study assessment as the tool to be used for curricular assessment in Grant Years 1 and 2. The case study assignment and associated rubric were revised to encompass all nine core competencies and address all four curricular modules, rather than screening/assessment and intervention only. CSWE determined that the nine core competencies would be measured via the case study assessment once per student after receipt of a sufficient amount of the curriculum as determined by the pilot school faculty. Faculty retained the flexibility to use student experiences from field practicum or an instructor-provided case study for the assessment. The SBIRT assessment tools were provided to faculty as an additional resource but were not used for project data collection.

Following feedback from the pilot schools in the January 14, 2020, monthly call, the case study instruction and rubrics were revised further to better align the assessment instructions for demonstration of the nine competencies and the assessment rubric. The assignment instructions were also explicitly labeled with the number of the competency meant to be elicited from the specific portion of the assignment to assist instructors in applying the rubric.

Creation of guide for development of case studies. For pilot schools where a client from the students' practicum was not to be used as the subject for the assignment, a guide was created to support the development of case studies that would meet the requirements for the assessment.

The guide included information on the structure and suggested components of the case study, the type of information to be included in each section, and the competency that students should demonstrate in response to the information provided in the corresponding element of the case study. The aim of the guide is to standardize assessment of the curriculum, while allowing for flexibility in implementation (see Appendix B).

Case study library. Three initial case studies were provided by the evaluation consultant that closely adhere to the guidelines for developing case studies. The evaluation consultant then solicited from faculty of the participating schools case studies involving substance use that they had previously used in their instruction. The case studies were selected to provide diverse client examples of gender, race/ethnicity, age, geographical setting (urban versus rural), and presenting problem. The evaluation consultant then reviewed and revised each of the case studies as needed to ensure their ability to elicit the nine core competencies as part of the assessment. A case study library of nine substance use case studies was created. Case studies are included in Appendix C.

Data Collection

Attendance was recorded at each monthly training session to measure faculty participation and training reach. A Qualtrix survey was used to collect both process and outcome data from the faculty at the 32 participating programs in May 2020, August 2020, December 2020, May 2021, August 2021, and January 2022 to coincide with the semester system. Faculty liaisons at the 32 participating programs were responsible for compiling and reporting data for their program. This included the number of students receiving curricular content in classroom and field practicum settings and the number of students achieving competency as measured by administration of the case study assessment and rubric. In addition, four qualitative questions

were included in the survey as part of the process evaluation. This feedback was used to guide provision of additional curricular resources and training during the project, as well as to inform CSWE of facilitating factors and barriers to implementation that could guide larger dissemination efforts.

Outcomes

Reach: Number of Students Receiving Substance Use Content

During the project period, CSWE partnered with a total of 32 colleges and universities to integrate the newly developed SUD curricula into social work programs. Twenty-two schools of social work participated in Year 1 of the project with 10 additional schools joining in Year 2. Three schools stopped participating in the second quarter of Year 2 due to staffing changes and program challenges as a result of the COVID-19 pandemic, leaving 29 participating schools (Objectives 2a and 2c). Implementation of the curriculum in participating programs commenced in spring 2020. Year 1 data represents implementation of the curriculum in the spring and summer semesters of 2020, with Year 2 data collection beginning in fall 2020 and continuing until summer 2021. Content on four curricular themes was disseminated during Year 1 of the project (theories of substance use; assessment; intervention; and Screening, Brief Intervention, and Referral to Treatment [SBIRT]). A fifth curricular theme was developed and disseminated in Project Year 2 (ethical and professional behavior). The table below represents the number of social work students receiving course content in each of the five curricular themes.

Course Content

	Year 1	Year 2	Total
Theories of substance use	518	1,642	2,160
Assessment	710	1,608	2,318
Intervention	734	1,807	2,541

SBIRT	610	1,467	2,077
Ethical and professional behavior	0	1,870	1,870

Note. Number of social work students receiving course content (Objective 5).

Field Practicum Content

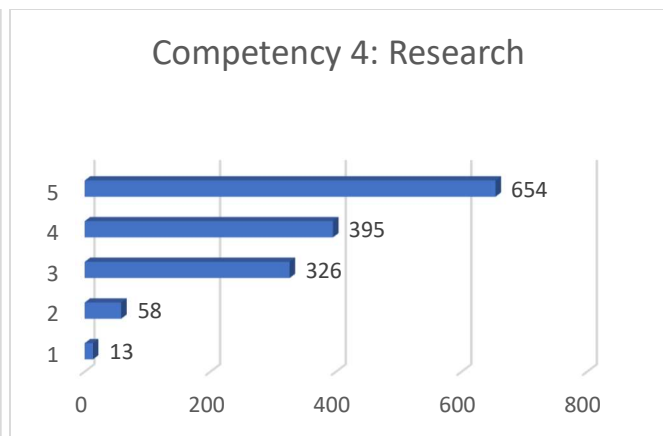
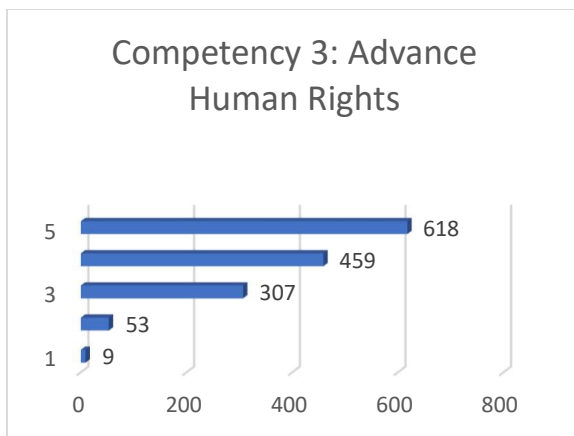
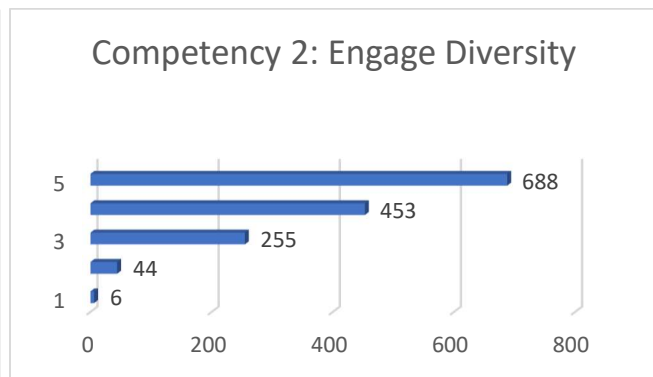
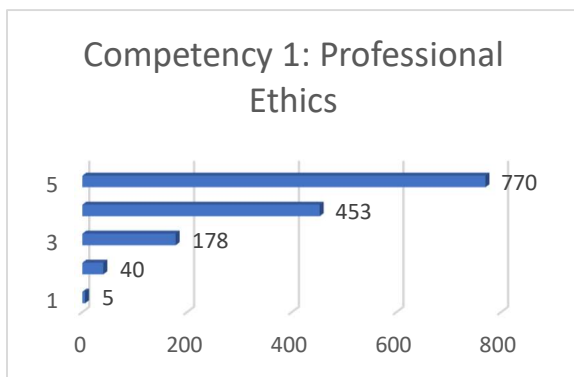
The project also sought to enhance the SUD-related learning experiences of social work students in the field practicum setting. The number of students participating in placements in substance use–focused practice settings was assessed (Objective 3b), as was the number of students receiving substance use content and experiences in practice settings that are not exclusively substance use focused (Objective 4; see table below). Nonspecialized field practicums met criteria for inclusion if 25% or more of the student’s time in the practicum was spent on substance use–related tasks. As with the delivery of course content, Year 1 data represents implementation in the spring and summer 2020 semesters. Year 2 includes fall 2020, spring 2021, and summer 2021.

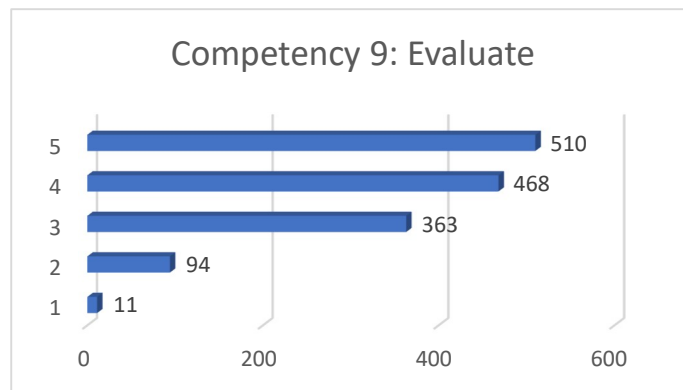
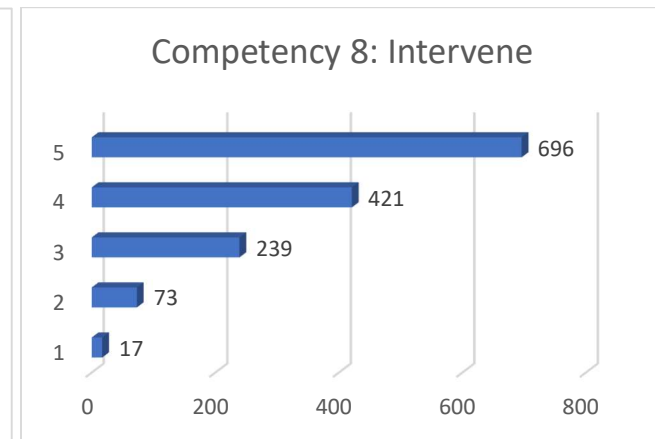
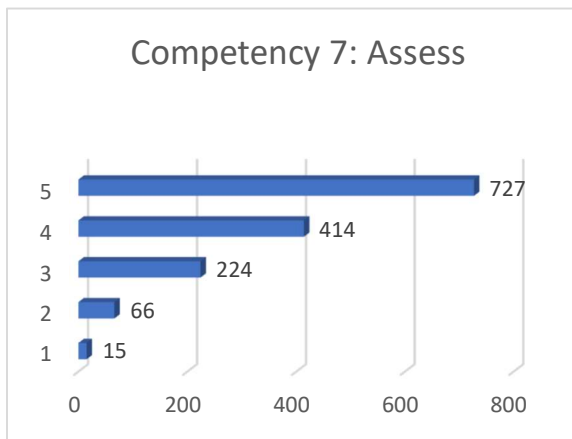
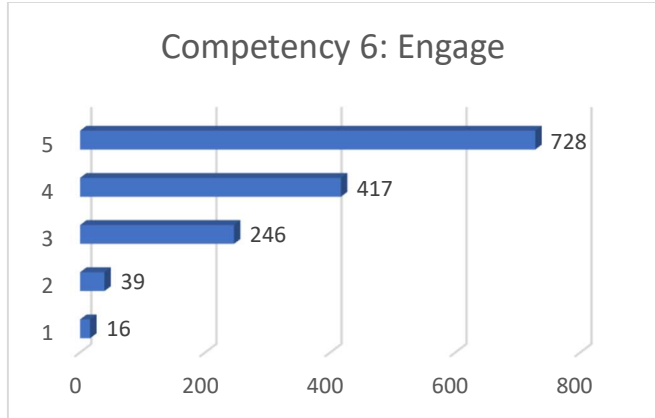
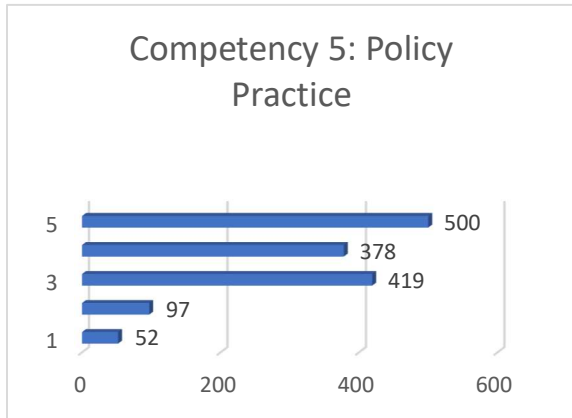
	Year 1	Year 2	Total
Specialized	223	618	841
Nonspecialized	843	1,382	2,225

Effectiveness: Students Demonstrating Competency

The case study assessment was administered to MSW students to measure performance on all nine CSWE core competencies following receipt of the pilot curriculum. Assessment

began at the close of the spring 2020 semester and concluded in August 2021. An anchored 5-point rating scale was used (5 = advanced competence; 4 = high competence; 3 = competence; 2 = emerging competence; 1 = precompetence) to measure individual students' achievement of each of the nine CSWE competencies. The charts below illustrate the distribution of levels of student competence demonstrated for each of the nine CSWE competencies (Objectives 6a and 6b). No significant differences were noted between Years 1 and 2 of the project, so the totals encompass students assessed for the entirety of the project period.





As indicated, the majority of students demonstrated advanced (5) or high competence (4) levels for all nine CSWE competencies. The distribution of student achievement is weighted strongly toward the higher levels of competence for all nine competencies. However, Competency 5 (Engage in Policy Practice) and Competency 9 (Evaluate Practice With Individuals, Families,

Groups, Organizations, and Communities) demonstrate a slightly wider distribution of competency levels among the students assessed. This outcome was not unexpected as policy practice and research are well documented as content areas in which social work students face greater challenges with engagement, confidence in skills application, and achievement of competency (see, for example, Morgenshtern et al., 2011, or Rubin & Parrish, 2007).

Additionally, the goals of the grant program were primarily focused on development and delivery of direct practice content. Outcomes for all competencies were well above the targeted percentage for Objectives 6a and 6b (80% achievement of competence as measured by a score of 3 or above on assessment rubric), with the fewest number of students achieving competence for Competencies 5 and 9 (90% and 92%, respectively) and the greatest number achieving competency for Competency 2 (97%).

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Appendix A

Case Study Assessment Instructions and Rubric

Case Study Analysis

General Instructions

Managing personal biases and using a strengths-based perspective, describe your approach to working with the client. Please use person-first, nonstigmatizing language throughout. (C1)

Engagement and Assessment

Describe your proposed engagement and assessment process with the individual.

Consider the following:

- What stage of change is the individual in? What barriers to engagement might you encounter? How will you address them using motivational interviewing and other strategies? (C6)
- What cultural, environmental, and developmental factors may be affecting the individual's substance use (C2)? Consider individual strengths (C1), along with other protective and risk factors. How might this affect their recovery (C2)?
- What systemic cultural, economic, and environmental factors are present that may positively or negatively affect the individual's substance use and recovery (C3)?
- What formal assessment(s) would you use (C7)? Explain your reasons for selecting this assessment tool(s), including the client's characteristics (C2), the drug of choice, the psychometric properties of the instrument (where applicable), and the evidence base for the assessment (C4, C7).

- Summarize your critical evaluation of the individual's substance use, including the application of *DSM-5* criteria, groupings of symptoms (e.g. Big 5 or other method), and problem severity (C7).
- Using a biopsychosocial perspective, what additional information would it be important for you to have to effectively intervene that is not present in the case study (C7)?

Intervention and Evaluation

Describe your proposed intervention and treatment goals. Consider the following:

- What level of care would you recommend, using the American Society of Addiction Medicine (ASAM) criteria as a guide (C8)?
- What intervention(s) would you apply and why? Consider the individual's demographic and other characteristics (C2), problem severity, and drug of choice. (C4, C8) Cite the peer-reviewed literature to justify your selection of the intervention and how it will address the presenting problem (theory of change; C4).
- What treatment goals would you identify? Consider addressing secondary gains, triggers for use, critical risk factors, and building of recovery capital. (C9)
- How will you know that treatment is successful? What clinical indicators or assessments would you use? (C9)

Organizational/Policy Recommendations

Based on the above, make a concrete recommendation for policy or practice procedures in organizations that would serve the individual and others with similar characteristics (e.g. gender, race, age, cultural background, economic/insurance status). The organization could be

your current or previous field placement, place of employment, or another organization you are familiar with. Your suggestion may be related to improving prevention efforts, more effective assessment or intervention, or supporting long-term recovery and well-being. For example, this might mean a change in agency procedures or personnel, expansion of intervention and supports offered, or building a relationship with other organizations/groups. The proposed change should reflect your knowledge of the population represented by the case analysis and how their characteristics, barriers, or experiences affect substance use. (C5)

Assessment and Intervention Rubric

Please assign a rating on a scale of 1 to 5 for each competency, with 5 = advanced competence and 1 = precompetence. The below rubric is intended to assist in anchoring your rating.

	Advanced Competence	High Competence	Competence	Emerging Competence	Precompetence
Competency 1: Ethical and Professional Behavior CAP, V	Effectively manages personal biases; uniformly uses a strengths-based perspective and person-first, nonstigmatizing language.	Manages personal biases, identifies multiple strengths and protective factors, and uses person-first, nonstigmatizing language.	Manages personal biases, identifies some strengths and protective factors, and uses person-first and predominantly nonstigmatizing language.	Employs limited application of strengths perspective, shows evidence of attempt to address personal biases, and uses some stigmatizing language.	Does not identify any strengths or protective factors. Personal bias evident. Uses stigmatizing language or projects information not present in case scenario.
Competency 2: Engage Diversity	Comprehensively applies knowledge of cultural,	Substantially applies knowledge of cultural,	Identifies most significant cultural, developmental,	Shows limited identification of relevant cultural, developmental, and	Does not consider developmental, cultural, or

and Difference K, CAP, S	developmental, and demographic factors to assessment process, selection and delivery of intervention, and support of recovery.	developmental, and demographic factors in the assessment process. Connects at least two of these to selection <i>and</i> delivery of intervention.	and demographic factors in the assessment process and relates at least two of these to selection <i>or</i> delivery of intervention.	demographic factors in the assessment process and no connection to selection and delivery of intervention.	demographic factors in the assessment process, selection, or application of intervention.
Competency 3: Human Rights K, CAP	Comprehensive identification of cultural, environmental, and economic factors that promote or inhibit substance use and recovery and explication of connection to these processes.	Above average identification of many cultural, environmental, and economic factors that promote or inhibit substance use and recovery. Connection of principle factors	Satisfactory identification of principle cultural, environmental, and economic factors. Connects at least two factors identified to substance use or to recovery.	Limited identification of cultural, environmental, and economic factors. Factors are not clearly connected to substance use and recovery.	Does not identify cultural, environmental, or economic factors that promote or inhibit substance use and recovery.

		to substance use and recovery.			
Competency 4: Research-Informed Practice K, CAP, S	Shows skillful application of peer-reviewed literature to select a standardized instrument and to identify an evidence-supported intervention that matches well the individual and presenting problem. Critically reflects on assessment's psychometric properties and on the strengths and weaknesses of	Selects a standardized instrument and intervention that matches individual and presenting problem. Rationale is presented for selection that includes strengths and weaknesses of the assessment for the individual. Substantial application of the peer-reviewed	Selects a standardized instrument that matches individual and presenting problem. Some evidence-supported rationale is presented for selection. At least one additional factor for exploration during assessment is selected and empirically linked to intervention.	Selects an assessment or intervention that is not a best fit for either individual or presenting problem. Additional factors explored during assessment are not empirically connected to intervention. Limited explication of theory. Some peer-reviewed citations are included but do not appear to be thoughtfully gathered or applied.	Rationale for selection of assessment is not addressed. Assessment selected is not standardized or is inappropriate for case scenario. Theory of intervention and/or research base is missing.

	assessment and intervention for the individual. Additional factors explored during assessment process are empirically linked to intervention. Intervention is evidence supported, with clear summary of theory and research base.	literature to select an evidence-supported intervention. Some additional factors explored during assessment are empirically linked to intervention. Theory of intervention is addressed.	Satisfactory summary of theory of intervention and research that supports efficacy of intervention and its application to presenting problem of case scenario.		
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Competency 5: Policy Practice	Suggestion for organizational change is feasible and well detailed. It is linked to	Suggestion for organizational change is detailed and linked to at least one population-	Suggestion for organizational change is sufficiently detailed and linked to theory	Suggestion for organizational policy change is made but is not clearly linked to theory of substance	Suggestion for organizational policy change is missing or unclear.
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	evidence-supported knowledge of population-specific factors that affect engagement, assessment, or intervention. Connection to theory of substance use is evident.	specific factor. Connection to theory of substance use is evident.	of substance use.	use or organizational practices.	
Competency 6: Engage K, CAP, S	Comprehensively identifies potential barriers to engagement and provides potential responses. Demonstrates knowledgeable application of	Identifies multiple potential barriers and offers more than one tool for responding. Demonstrates good application of principles of MI to significant	Demonstrates awareness of some potential barriers to engagement and offers at least one response. Demonstrates knowledge of MI principles	Demonstrates awareness of one potential barrier that may be present but does not offer any responses. MI is addressed, but principles are not applied to case scenario.	Does not identify potential barriers to engagement or pathologizes barriers present and does not present responses.

	principles of motivational interviewing (MI) to engage client and enhance motivation.	features of case scenario.	and evidences some application to case scenario.		Application of MI principles is missing or not explicated.
Competency 7: Assess K, CAP, S	Identifies standardized assessments that are best fits for substance and individual characteristics. Clear application of <i>DSM-5</i> criteria to symptoms and grouping of symptomology (e.g. Big 5). Identifies clinically	Identifies standardized assessment that is a best fit for substance and individual characteristics. Clear application of <i>DSM-5</i> criteria to symptoms and some grouping of symptoms. Identifies at least one clinically	Standardized assessment selected is a good fit for substance and individual characteristics. <i>DSM-5</i> criteria are applied, with some identification of types of symptoms.	Assessment selected is not the best fit for the substance and individual characteristics. <i>DSM-5</i> criteria are addressed minimally without grouping of symptoms. Limited additional information that may be needed is identified, but clinical significance is not explicated. Clear	Assessment selected is not appropriate for substance or individual characteristics and/or student confuses screening and assessment functions. <i>DSM-5</i> criteria are missing, and problem severity is not

	significant additional information that may be needed and how it may be used in treatment planning.	significant additional area for assessment and provides rationale for assessment.		connection of assessment data to be collected for intervention planning is not made.	addressed or not supported by case information. No connection is made between assessment and intervention planning.
Competency 8: Intervene K, CAP, S	Intervention is culturally and developmentally appropriate, matched to problem severity, drug of choice, and individual's risk and protective factors. ASAM criteria are clearly linked to appropriate level	Intervention is culturally and developmentally appropriate, matched to problem severity and drug of choice. All critical risk factors are addressed, along with at least one modifiable protective factor.	Intervention is culturally and developmentally appropriate and is satisfactorily matched to problem severity and drug of choice. Most individual risk factors are addressed. Level of care	Intervention is not matched to at least one of the following: culture/developmental stage of individual, problem severity, or drug of choice. There is limited consideration of individual risk and protective factors. ASAM criteria are minimally addressed.	Intervention is not matched to individual, problem severity, or drug of choice in critical ways. ASAM criteria are not addressed and/or level of care recommendation

	of care recommendation.	ASAM criteria are linked to appropriate level of care recommendation.	recommendation is on target.		is not appropriate.
Competency 9: Evaluate K, CAP, S	Treatment goals address critical risk and protective factors, are aligned with the intervention selected, are recovery focused, and are measurable. Uses a combination of subjective and objective indicators to assess treatment progress.	Treatment goals address all critical factors and at least one protective factor. Goals are aligned with the intervention and are concrete and measurable with at least two indicators identified.	Treatment goals are clearly stated and satisfactorily address all critical risk factors of case presentation. At least one form of measurement is clearly described, along with indicators.	Treatment goals are identified but may not address at least one critical risk factor of case presentation. Measurement is minimally addressed, but greater specificity is needed.	Treatment goals are not clearly identified or do not address critical concerns of case presentation. Measurement is absent or inadequately matched to treatment goals.

Appendix B
Case Study Development Guidelines

The following six components are recommended for inclusion in all case studies designed for use in assessing student competency in the Council on Social Work Education (CSWE) Practitioner Education project: (1) setting, (2) demographics, (3) presenting problem, (4) brief background of substance use and treatment/change efforts, (5) current symptoms and use, and (6) personal and contextual factors. An additional section below describes how students apply knowledge obtained in their courses to the case study for competencies requiring synthesis of information contained in multiple sections of the case study (*C4, C5, C9*).

Setting

For the purpose of the case study, the student will encounter the individual in an outpatient setting. In their role, the student will be responsible for both assessing the individual and implementing the intervention they select.

Demographics

Describe the demographic characteristics of the individual, particularly those that may affect substance use and trajectory of use, drug of choice, access to treatment, or intervention selection and efficacy (*C2*). The demographic characteristics should also lend themselves to students' identification of systemic factors that affect substance use or receipt of intervention (*C3*). This may include factors such as family status, geographical/community context, gender, gender identity, age, race/ethnicity, cultural background, disability and ability, sexual orientation, economic/insurance status, immigration status, history of trauma, religious/spiritual orientation, tribal sovereign status, or previous military service. Factors included should also reflect a stigmatized characteristic where students typically struggle to maintain a neutral perspective or a

strengths-based approach (e.g., substance use during pregnancy, sex work, driving while intoxicated, “dropping out of” or quitting previous interventions/change attempts). (C1)

Presenting Problem

Describe what precipitated the individual engaging with your student. For example, was the client’s engagement voluntary or involuntary? If voluntary, did they engage under duress, such as pressure from a family member, partner, or employer? What is the individual’s perception of their own substance use and their emotional state? This section should provide clues as to the motivation of the individual (both internal and external) and where the student should start to engage the individual (C6). This section may also provide initial clues to risk and protective factors that might shape the engagement and intervention process (e.g., insight into their substance use as being problematic, healthy relationships that the individual cares about, maintenance or loss of employment; C7).

Brief Background of Substance Use and Change Attempts

Provide a synopsis of the history of substance use, including age of first use, duration/length of use, any relevant factors that coincided with the start and acceleration of use (e.g., mental health symptoms, loss of employment, trauma, influence of peer group, other co-occurring problems; C8). This history should also be consistent with the demographic factors previously outlined (C2). Summarize any previous interventions or attempts to reduce/cease use that may assist in gauging problem severity (C7) and shaping/informing intervention recommendations (C8).

Current Symptoms and Use

Describe the individual's current substance use, including frequency, amount, substance type(s), mode of administration, and relevant patterns of use. Summarize any symptoms of use, such as adverse effects on mental or physical health and other consequences the client might be experiencing as a result of substance use. Include enough information that students can roughly match the data to the 11 *DSM-5* criteria for substance use disorder (e.g., increased tolerance, withdrawal symptoms, impact on social, family, and employment domains). (C7)

Personal and Contextual Factors

Summarize other personal and contextual factors that may affect the course of intervention (such as the outcome goals or significant others to be included in services) and/or referrals that might be made (C9). The description should identify both protective and risk factors. Personal factors might include information such as co-occurring mental health symptoms not previously described, strengths of the individual, or positive leisure activities. Contextual factors should also focus on protective and risk factors that affect substance use and success of recovery. This might include information such as the presence or absence of structure (e.g., employment or other daily commitments), the health of familial and social relationships, availability of the substance of choice, and recovery support systems.

Application of Additional Competencies

C4. Students will combine knowledge of available assessments, their application, and psychometric properties to the case study information provided on demographics (Demographics) and substance use (Brief Background of Substance Use and Change Attempts;

Current Symptoms and Use). They will combine knowledge of evidence-supported interventions with case study information presented on demographics (Demographics), drug of choice (Current Symptoms and Use), problem severity (Brief Background of Substance Use and Change Attempts; Current Symptoms and Use), and protective and risk factors (Presenting Problem; Personal and Contextual Factors). Students will cite relevant peer-reviewed literature.

C5. Students will combine their knowledge of organizational practices and local service systems to identify proposed changes that address client needs, using case study information on the individual's characteristics (Demographics), substance(s) used (Current Symptoms and Use), and protective and risk factors that are a high priority to address (Personal and Contextual Factors).

C9. Students will combine knowledge of measurement principles and tools with information in the case study on individual characteristics (Demographics), individual priorities and immediate concerns (Presenting Problem), drug of choice (Current Symptoms and Use), and the risk and protective factors present (Personal and Contextual Factors).

Appendix C

Case Studies

Case Study: Jordan (White, Adult Male)

Jordan is a 33-year-old, White, heterosexual male who reports no religious background. Jordan arrived at the drug and alcohol access center 8 months ago as a self-referral. He was motivated to seek treatment by a probation stipulation after a charge for heroin possession 1 year ago. He has maintained abstinence from heroin for 8 months and is being referred to you due to the resignation of his previous counselor. He has fulfilling hobbies, part-time employment, and a strong support system. At this time, his goals are to quit smoking and transition from intensive outpatient to outpatient treatment.

Jordan moved back to the East Coast from California, where he had been pursuing his dream of being a business entrepreneur before he began using. He was introduced to drugs through his social circle, eventually becoming dependent on black tar heroin. He was eventually arrested for possession of a controlled substance and incarcerated. During his incarceration he stopped using, relapsing only once following his release.

Jordan regularly attends Narcotics Anonymous (NA) meetings and enjoys the fellowship that comes with it. He has a sponsor, and his sponsor has been key in introducing Jordan to a community of people who support him and whom he can talk to when he has the urge to use. Jordan also has a girlfriend and a positive relationship with his mother who lives in the area. He also meditates regularly, often meditating in the morning to clear his mind before going to work, or to decompress at the end of the day. Despite this, Jordan cites cigarettes as the main way he was able to keep from using heroin after prison. Whenever he feels anxious or has drug cravings, he relies on nicotine instead of heroin. Jordan fears that without cigarettes as an outlet he will relapse, because he hasn't done the stepwork with NA and does not feel ready to do so, despite going to meetings for 8 months.

Jordan describes his anxiety as being primarily triggered in social situations. When he feels that someone is not putting forth the same effort that he is, he feels uncomfortable and disconnected. He feels a lot of pressure, especially in “high-stakes” situations where he is expected to make a good impression on someone. This triggers feelings of self-doubt and inadequacy and leads to him becoming anxious and withdrawn. In these situations, he uses smoking as a way to control his anxiety as well as an excuse to physically escape (i.e., I need to go have a smoke).

Jordan is concerned about the impact of smoking a pack of cigarettes a day on his health and has been thinking he’d like to quit, but he does not have a plan yet to do so. He says that if he did quit, he would probably just go “cold turkey” since the withdrawal from nicotine can’t be that bad.

Case Study: Sadie (White, Adult Female, Rural)

A colleague of yours at a multiservice behavioral health agency presents the following case in group supervision with six other workers. The client (Sadie) was referred to your colleague by the crisis worker at the city's Temporary Assistance to Needy Families (TANF) office. The TANF intake worker referred Sadie to crisis services after completing her TANF application with her. Your colleague's information comes from the TANF intake worker, the crisis worker, and a mental health worker at a rural clinic who treated the client during her first pregnancy as a teenager 6 years ago.

Sadie is a very thin, dark-eyed, 26-year-old female, one of four children born to parents who own a farm/ranch near Fargo, North Dakota. She completed high school but never earned her diploma; she said this is because she stayed home with her frail mom too much during her senior year. She is adamant that she is not a dropout though. Her oldest brother, Rob, was an alcoholic who died falling off an all-terrain vehicle when he was 26, her age now. She reports that her father, Rob Sr., has not had a drink since that dark and fateful day. Her mom, who was already thin, grew even thinner after Rob Jr.'s death and spent some time in the hospital to gain weight. She died late last year "from a weak heart, same as *her* mom." Sadie reports sheepishly that all the women in her mother's line have weak hearts, and that is why they are all so thin. Sadie has two older sisters: Katie, who is 31, and Sue Anne, who is 29. Katie went into the army right out of high school (she had to gain weight to pass the intake physical). She married a Catholic man from Puerto Rico, where she now lives with her six children and her husband's extended family. Her sister Sue Anne has not married. Sadie dramatically reported, "I think she has a *girlfriend* or something ridiculous like that." Sue Anne has remained on the farm that she helped her father to modernize. They currently raise sugar beets and hogs and make the most of

federal farm subsidies.

Sadie has fled to Missoula, Montana, after leaving a tumultuous marriage to Freddy, a 32-year-old long-haul truck driver she met in Fargo when she was just 20. He is from Great Falls, Montana, but has extended family in Missoula. They met in a “honky-tonk bar.” She smiled as she remembered that he was a really good dancer. He would buy her drinks all night if she wanted him to. Her first child Timmy (now age 6) was born when they lived in an apartment in Great Falls. She states that she was happy then but that Freddy would drink when he was not on the road and accuse her of cheating. She would drink just to get even with him. He later became physically abusive—shoving and slapping her sometimes—but would not hit her after she got pregnant with their second child. He would always threaten to hit her *after* the baby was born though, and she was afraid much of the time. After the birth of Michael (now age 4), the abuse did resume, so she lied and told him she was pregnant again. She soon did become pregnant again with Peter, now age 2. When asked if the three children were all that she and Freddy had, she said no. When asked to explain, she told the TANF worker, “Petey is not really Freddy’s, but he would kill us both if he finds out, so please don’t put it on the form. He has a way of finding out *everything*; it’s like magic or something!” She refused to give the name of Petey’s biological father or any information about him, which is legally required for the approval of a TANF assistance claim.

Sadie fled Freddy and their place in Great Falls a few weeks ago and went to her sister-in-law, Sarah’s, house here in Missoula. However, Sarah now says that Sadie’s got to go because her kids and Sarah’s dogs don’t get along. She can stay a few more days, she says, until her welfare checks get started, but that’s it. Sadie reports that she cannot go home to the farm because Freddy’s mother was Native American (tribal registered), and her dad will not let her

kids or Freddy on his property because of that. Her sister thinks this is ridiculous, but neither of them would ever disobey their father. She says her sister and her friends are all “weird,” and she would never live with them anyway. Sadie states Freddy is still on the road right now and will probably “pound” both her and his sister Sarah if he ever figures out where she is. She looked visibly shaken when she mentioned this—genuinely afraid. She states that she really needs the welfare now.

As part of her intake, Sadie was asked if she ever used drugs and said, “Not anymore and not now, because I can’t get welfare if I did, and I don’t.” She was asked the four CAGE screening questions and answered yes to three: cutting down, feeling guilty, and having an eye opener. She has been referred to your agency for further assessment of a possible substance use disorder. There is a 4- to 6-week waiting list for services, but because she is technically homeless and has children, she could be fast-tracked.

Case Study: Jennifer (White, Adult Female)

You are performing an intake assessment at a community-based substance abuse treatment clinic. Jennifer is a 26-year-old White American who completed college 2 years ago. She states that it took her 6 years to complete college because she “partied out” a couple of times and had to work her way back. In fact, the second time, her parents cut her off, saying they were not going to subsidize her drinking lifestyle any further and that she was on her own to complete college. She did. She was assessed by the college counseling center and told to go get “a lot more help than they had,” but she never did because she did not want to quit. She had a DUI charge dismissed in college and once, a year and a half later, got a ride home by the police, but she was never really sure what for and hasn’t wanted to go back and ask them, though she was terrified for a while, waiting for something to come in the mail, like a summons, but it never did. “Even that,” she says, “didn’t make me stop drinking.”

Jenny states she has been pregnant twice, the second time very recently, and in both situations terminated the pregnancy. She states that she feels like a horrible person because of the second pregnancy, having promised herself that she would never go through that again after the first one, but birth control makes her sick. When asked further about this, she indicates that she has always been a very moral person and that she felt she could forgive herself after the first one, but having done this twice she feels she’s going to hell and that she deserves to. During the interview she says, “I sometimes wish I *was* dead. I don’t see what the point of living is; I don’t seem to be in control of anything.”

She reports that she began drinking in the ninth grade of high school and felt from the start as if it did something for her that it wasn’t doing for other people. Some of her friends would party heavily, but soon after the onset of drinking, she just wanted to drink all the time.

She stated somewhat casually, “I can drink a quart [of hard liquor] you know. I have to in order to be able to really feel it anymore.” She controlled herself early on by restricting her drinking to specific periods of time and places. This was a strategy that worked well until college, when she would set benchmarks for herself and, as she called it, “blow it.” The first time that she withdrew from college she blamed it on being depressed after her abortion, which her parents blamed on her drinking lifestyle. She agrees that she never would have become pregnant then if she had not been drinking. The second time she withdrew from college she reports she had a whole semester of basically binge drinking and didn’t go to any of her classes. Nonetheless, she “regained control of herself” for a while and completed school.

She has used cocaine but stopped because she reportedly wound up “doing stupid stuff.” When asked what stuff, she said that she didn’t want to talk about it. When asked if it included other drugs, she indicated she had also snorted heroin a couple of times because it was powdered just like coke, but she would never shoot anything—and it was not a habit—either of them. She has tried “most of the pills” but didn’t like them. Alcohol was more reliable. She states she loves pot but never gets anything done when she smokes, so she only does it sometimes. She tried meth but hated it—not relaxing at all. She is irritated that you are asking about all this stuff she does not have a problem with. “It is alcohol,” she says. She used to go out drinking with friends, but most of them are “pissed at her” and it is cheaper to just drink at home alone now.

Her college degree was in biology, and she is currently employed by a high-technology company doing what she describes as “lab rat” work, and she really likes it. She prepares slides and specimens and enjoys the company. She was dating one of the lead researchers, but he recently dumped her to get back together with his wife. She stated that “he was the father for the second kid.” Jenny reports that after this breakup and the resulting abortion, she started drinking

really heavily (“more than a quart?” you ask; “way more,” she says) and missed work for several days—again. Unable to get her nerves together for work, she states that she would drink just a little in the morning before going in to stop shaking and to make her head stop hurting so bad. One month ago, she briefly tried to stop drinking, but she “freaked out” and woke up much later on the floor. She is not sure, but she might have had a seizure. Recently, one of her coworkers said that she smelled like alcohol and that she was going to tell the boss. She lied and said she had spilled some formaldehyde and now feels wicked guilty about lying about drinking—on top of the abortions. She feels as if people at work are looking at her, that they know everything now. She quit another job over a year ago because she thought she was going to get caught. This recent “threat” from her coworker terrified her enough that she is coming to you voluntarily. She states, “It’s piling up. My life’s a mess, and I can’t go on like this. I have abortions, the cops drive me home, I’m losing my job. This isn’t me; it has to stop. This has to end, and I will find a way to end it if you can’t do something.” When asked what she would be willing to do for treatment, she said, “My insurance will cover it if I have to go away and then they can’t fire me at work because of ADA. Or I could take FMLA, but I’d rather they didn’t know about it.” She states she will do anything to get her drinking under control, but she does not want to take “those pills.”

Case Study: Suzanne (Pregnant Female, Adult)

Suzanne has come by the free “drop-in” counseling clinic where you work to get some information and advice. Suzanne is a 22-year-old single woman who has been living with her boyfriend Jack for the last 4 years. She and Jack have been using heroin regularly for as many years.

When Suzanne was 10 years old, her father, whom she says was a very heavy drinker, left her mom and the kids and never came back. At 14 she started drinking and smoking marijuana. At 16 she dropped out of high school, and at 18 she moved in with Jack. He introduced her to heroin.

She reports using about half a gram of heroin per day just to be able to function and feel comfortable. Jack doesn't work, so in order to pay for the heroin and pay the rent on their apartment, Suzanne works the streets at night. She usually drinks four or five beers each night before going out to work. If she can't score enough heroin, she will try to score either some Xanax or Klonopin to “tide me over until I can get some ‘dope.’” She says she has tried cocaine but “really didn't care for the high all that much.”

Suzanne tells you that the alcohol and heroin help to calm her nerves and get her through the night. She and Jack are not having sex all that much. When they do, he never wears a condom. He says that's what makes him different from her “john's,” “which is true because I won't work without a condom.”

Lately, she has noticed that her breasts have become swollen and tender. She also hasn't had her period in the last 12 weeks. She is pretty sure she is pregnant and knows it's her boyfriend's baby. However, she's not sure she can stop using heroin or work to have the baby even though Jack wants her to keep it. She's really confused about what she should do and is

asking you to help her make some decisions. Her friend who works with her at night told her not to stop using heroin if she is pregnant “because it’s worse for the baby than to keep using.” “I just don’t know what I should do,” Suzanne says.

Case Study: Tyler (White, Adolescent Male)

Tyler is a 17-year-old single Caucasian male who lives with his mother and his 15-year-old brother. His dad is a sales rep and is on the road during the week. You work as the school counselor in the suburban area in which Tyler's family lives. Tyler has been referred to you because teachers report that he is disruptive in the classroom and often fails to hand in homework assignments. Tyler said:

When [my dad is] home on the weekend, he just drinks and watches the ball games on TV. When he gets drunk, he yells at me and my mom and throws shit around the house. He drinks all the time that he's home, but he can't hold his booze. Like he's a total lightweight. Mom also drinks. Watch out when they both get "lit." Man, the fur really flies. We've had the cops out several times. I just take off when they start gettin' into it.

I started drinking and smoking when I was 13, in the eighth grade. It was a total drag, not that any of the other grades were any better, but all the kids were talking about high school and the classes they were going to take, and me, I was just trying to figure out where I was gonna get money for my next pack of cigarettes. Now I smoke about a pack a day, plus a couple of joints too. I have a cup of coffee in the morning before school, and that's it. At night, I'll drink three or four beers, plus a few shots of vodka. On the weekends is when I really get down to partying.

I've played around with lots of stuff. You know, trying to see what's out there. I've tried pot, coke, mescaline, XTC, mushrooms. I've even shot up a few times. It's no big deal. When I'm partying, I like to mix things up a bit. Maybe do some tequila and mushrooms, depends on what's going on and who's around. If I drink too much, I black out. I've even OD'd a few times. But, hey, it wasn't any big deal or nothing. I do like speed though. If any drug is my favorite, aside from cigarettes and coffee, it'd be "speed."

I saw a doctor when I was 8. My folks took me. They said I was out of control. The doctor said I had attention deficit disorder and gave me Ritalin. It helped a little, I guess. I don't know much about it. Right now, except for partying, I don't take any medication.

Then there's my brother, a complete math "geek." Always gotten good grades, never been in trouble; responsible, dependable, healthy, and clean. He's a parent's wet dream, and I'm his evil twin brother.

Case Study: Renee (Native American, Adult Female, Rural)

You are working for a human service agency in a western state in the United States. Your agency has a contract to provide outpatient services as well as having a Memorandum of Understanding with Health and Human Services and a hospital that offers behavioral health services, including inpatient, residential, and partial hospitalization programs; however, the hospital is 150 miles away from your agency. During the winter, it is not unusual for the temperature to be 30 degrees below zero and to have wind chill temperatures at 90 degrees below zero. There are four other clinical social workers, a clinical psychologist who is also the agency director, and a psychiatrist who drives up to the clinic twice a month to offer psychiatric care in your rural community of 15,000 people.

You have received a referral to work with Renee (her name has been changed to protect her confidentiality), age 29. Renee is a member of the Indian Nation located 50 miles northwest of your community; however, she and her significant other, Butch, age 35, live in a small home in the rural country about 25 miles outside of the Indian Nation. Renee has been referred to services because a week ago. Law enforcement was referred to her home after Butch became intoxicated, held a gun to her head, threatened to shoot her and then himself, forced sexual activity on her, and then passed out. At this point, Renee was able to escape and called law enforcement; they arrested Butch, who is currently in jail but is expected to be released within the next week. Renee is disturbed by the events and has been having nightmares and ruminating thoughts on the events. She is unsure whether calling law enforcement was the correct action and is worried Butch is not going to be able to forgive her. Renee and Butch met when she was 16 years old, and they were both working at the ice cream and burger restaurant in town. She reports it was love at first sight. Butch has been estranged from his family since the age of 17 when he

had a fight with his family and left home. He has had no contact with his family in the last 18 years. Renee is close to her family. She has three siblings who live in the Indian Nation. Both of Renee's parents are deceased—her mother due to a motor vehicle accident and her father to cancer and cardiac issues that were probably related to his lifelong smoking and his alcohol use pattern of four to five drinks a night, which Renee attributes to as a normal drinking pattern for the Indian Nation. Renee reports she feels really connected to Butch and is dismissive of the events leading to the referral; however, she does not want it to reoccur. She is angry with the no-contact order a judge put in effect and is worried this will lead to Butch connecting with someone else and ending their relationship. Renee is terribly anxious about ending up alone and being abandoned. Renee thinks if she could get pregnant, Butch would have to stay; however, his substance use pattern is concerning to her.

Renee reports that Butch drinks 24 out of 30 days a month. He does some seasonal work with cattle, which pays well, but is rather unstructured and is accommodating to his substance use. When Butch does drink, he will have five to eight drinks on average. She reports, "He drinks just a little bit more than my Dad did." Butch also smokes cannabis daily, which Renee is unconcerned about because "a lot of people on the reservation smoke weed, and if it keeps him happy, I guess I would be OK with it." About 10 times a month, Butch takes the opiate medication Percocet (20 mg), which is prescribed by a physician because he has a lot of pain and soreness after moving the cattle from one area to another. In observing Butch, Renee has witnessed him taking twice the dose of what the doctor prescribed, but since he only takes it one out of three days, she thinks this is not a significant issue. Both Renee and Butch have smoked crystal methamphetamine on an occasional basis. Renee reports she did it because she was curious and bored and hasn't used it in the last 3 years. Butch will occasionally smoke it. Renee

doesn't know how much he uses but doesn't think it is "all that much." She reports he does this because he likes how it makes him feel, but he is bored and really likes having sex with her after using. Renee also reports that Butch sells cannabis, but "not that much, maybe 5 to 6 ounces a month."

She reports her concern about Butch's substance use as a 4 out of 10. She has watched the television show *Intervention* and wishes this could happen with Butch, but she doesn't think it would help him and then wonders if she is overreacting to his substance use. Although there is an active recovery community in town, with AA, Al-Anon, and NA meetings, she is reluctant to go because "everyone will be gossiping about me, and Butch already has enough people that don't like him." Her siblings have encouraged her to move out of her home and stay with them in the Indian Nation, but Renee sees this as being too remote and isolating for her to seriously consider.

Renee is seasonally employed by the school district as a cook at an elementary school. She is off work during the summer, but this is typically when Butch works. They have no children; although she would like to have children someday, Butch would like her to become pregnant now. Renee's reluctance is related to Butch's substance use and his inconsistent work history. She is worried she will be too isolated in the community if he continues to fall apart due to his addiction. Although Renee is relatively intelligent, she reports she learns by doing things and doesn't particularly like "book knowledge." Neither Renee nor Butch has had prior experience with law enforcement, which is why Renee is sure the legal system will not make a big deal out of what happened because Butch was drunk at the time.

Renee identifies her goal for treatment as being to reduce her fear and anger resulting from Butch's assaulting her. She wants to be a better partner so he doesn't have to treat her like

he did when he attacked her. She wants to respond more effectively to his substance use and to figure out how to get him to stop or cut back on his substance use pattern. Finally, Renee wants to develop better insight into her own actions in this relationship and how she can take better care of herself, given the relational dynamics with Butch and the rural setting where she resides. She reports that she knows Butch is really sorry about what has happened, although she has not had contact with him since the night of his arrest. She wants you to submit a letter to the judge requesting the no-contact order should be lifted so she and Butch can begin marital therapy with either you or someone at your clinic.

Case Study: Mary (Adolescent Female, Rural)

Mary is a 17-year-old female who has come in for an assessment with you. Mary lives in a small farming community about 40 miles north of the agency where you work. She has been referred by her high school social worker, who has a supportive relationship with Mary and has vouched for you as a caring person who can be helpful. Although you work with clients on an outpatient basis, your treatment center also offers partial hospitalization and intensive outpatient treatment levels of care for both adults and adolescents. Your agency also has a contract for inpatient detoxification if the patient needs medical support to detox. Mary is accompanied by her mother. You initially met with Mary to complete the biopsychosocial assessment, which has taken several hours, and then gathered collateral information from Mary's mother. The following information has been obtained.

Mary, a junior, was recently caught by the vice principal for drinking alcohol in a women's restroom during a basketball game at the high school. She is in jeopardy of being expelled from school due to the school district's zero policy against alcohol and drug use. Her social worker has been advocating for the school to give Mary another option than expulsion and is advocating for the school to allow for treatment as an alternative. Although Mary dislikes school and the rigidity of the structure of school, she does not want to be expelled. She is on track with her credits and typically gets good grades. Her GPA is 3.2 on a 4.0-grade scale. Her main motivation for wanting to stay in school is graduating with her friends, and she states, "If I get kicked out and have to go to some bull-crap online school, I am going to drop out." The school district has several verbally outspoken parents who are demanding the zero-tolerance stance be upheld, and the principal and school board tend to give in to this group of parents.

Mary was initially guarded but opened up during the course of talking to you. Mary reports she drinks alcohol 4 days a week, typically Wednesday through Saturday. When she drinks alcohol, she estimates she will drink five to eight standard drinks of hard liquor. She especially likes drinking vodka. She started drinking regularly when she was in seventh grade, when she was 13 years old. She recognizes she is drinking more than she has in the past. She admits she drinks more days of the week, and when she does drink, the amount she consumes has gone up quite a bit. She has drunk to the point of having blackouts and, in the last year, has averaged having a blackout every other month. She likes drinking because all of her friends drink and there is nothing else to do to have fun. Both her father and paternal grandfather were alcoholics. Her father is deceased from smoking and hypertension, and she has a weak relationship with her father because of his drinking. She states, “I love him and I know he loves me, but him and mom can’t stand each other, and he is really just a drunk who walked out on us.”

In addition to her drinking, Mary smokes cigarettes at a frequency of four cigarettes a day (about six packs a month). She also smokes cannabis 20 days a month, and when she smokes, she smokes “a bowl,” which she estimates is about \$7.00 worth of cannabis. Mary will also snort about a ½ gram of cocaine once or twice a month since she turned 16. She likes using cannabis because it is a pick-me-up when she is socializing with her friends. Mary has a boyfriend who also uses substances. He is encouraging her to snort some opiates he crushes up, but so far, Mary has resisted engaging in that behavior. Mary reports her mother knows about her drinking but not her cannabis or cocaine use. She states, “Mom doesn’t care about my drinking. She was drinking when she was my age, and everyone in our community drinks.” She knows her mom would “freak out if she knew about my cocaine use.”

Mary reports she has been with her boyfriend, age 19, for the last 5 months. She reports, “He is sorta a bad boy, but he takes care of me.” She states he deals cannabis, gets in fights, and generally does what he wants to do. They met at a friend’s party. He has been using narcotics but, since they can be difficult to get, is thinking about trying heroin. Although he doesn’t have a job, he always seems to have money. Mary thinks he gets money from gambling, but she really doesn’t know where his money comes from. They have been sexually active. She reports she wants him to use a condom, but he won’t use them, claiming he doesn’t have any, but still pressures her to have sex. She has also noticed, when she has gotten condoms from the nurse at the high school, that the condoms have broken, and she wonders if he is doing this on purpose, although she is afraid to confront him; Mary is worried he is trying to get her pregnant, making statements like, “You’re going to give me a son, right?” He also talks crudely about her in front of her to his friends. These behaviors make her uncomfortable, but she feels she has been ineffective at advocating for herself in a healthy manner.

Mary was born and grew up in western Wisconsin in a small community along the Mississippi River. When she was 5 years old, she was lured down to the river by an older boy (13 years old), who sexually assaulted her under a bridge. She estimates she was fondled and forced to engage in other sexual acts she did not describe. She becomes tearful as discusses this. She reports she was terrified she was pregnant and it was her fault. As she remembers the event, she thinks she was away from the house for about 3 hours and her parents did not notice she was gone. She never disclosed this to her family because they would be mad at her for what she did. She reports she thinks about this, and when she is pressured by her boyfriend to be sexually active, she struggles to assert herself and take ownership of her choice to be sexually active with him.

Mary works about 15 hours a week at the local grocery store. She is highly thought of and is diligent in her employment. She likes making the money, although she admits most of her money is spent socializing and using substances. She would like to get a better job at a retailer in town, but she is anxious because they give urine drug screens, and she is not sure she will pass the test. Mary acknowledges many of the teenagers at the grocery store are friends and they party together on the weekends. Mary is unsure of her long-term plans. She would like to go to college, but no one in her family has ever gone to college, and her mother becomes tearful when she thinks about her daughter going away to college; her mother doesn't understand why Mary doesn't just go to the local technical college to save some money.

Mary is the youngest child. Her two older siblings do not live in the area. She describes being close and is sad because they left home and have maintained inconsistent contact with her. Her oldest brother, age 27, is a corporal in the marines. Although he is stationed in California, Mary is worried he will be deployed to some other part of the world. She reports he acted as her father when she was growing up. Her next sibling, Dave, is 21 years old and is close to her emotionally. She worries about Dave because he has struggled with substance use disorders and major depressive disorder. Dave attempted suicide 2 years ago, and the thought of losing Dave to his addiction or depression terrifies Mary. She does her best to help him out when he is down and lectures him on his need to stop using drugs; she feels like a failure because she has been unable to convince him to stop. Furthermore, when Dave points out she is a hypocrite because she uses, Mary feels ashamed, although she thinks her substance use is different than his.

Mary's father is not a part of the family. When Mary was 8 years old, her father came home drunk from the bar. A fight ensued between her mother and father, and the police were called. He blamed her mother for the legal difficulties and moved out. Since that time, he has

been marginally engaged in Mary's life. He will call her every 2 or 3 months, but he does not text or use social media to connect with her. His alcohol use disorder has continued to progress, and Mary sees his use as another failure on her part. She wonders what she could do to get him to be more present in his life and wonders whether, when she turns 21, she should start hanging out at the bar he frequents to get to know him better.

Mary likes the sense of community that exists growing up in the small town she resides in. She likes the sense of community and knowing everyone in town; however, she also feels confined and is worried about her limited options. She feels confined by the need to conform to the community standards and is worried she will become trapped the way she thinks her mother is trapped by her job working in the cafeteria at the middle school in town. Mary thinks she would like to travel but doesn't see herself following in her brother's footsteps and joining the military. She is worried her situation at her school will eliminate college as an option. She is worried that even if school works out and she graduates, she has no idea how she would pay for college because of the family income levels. She has not looked into the expense of college or how financial aid might be available to make this an option for her. She has not visited any colleges and vacillates between going to a large university, such as the University of Minnesota or the University of Wisconsin, with 50,000 other people versus going to a really small college 100 miles away from home as a few of her friends are doing, because the small school is so expensive.

She has also thought about just moving to Minneapolis and getting a job but is too unsure of herself to just pick up and relocate to a larger community on her own. She states, "I'd have no friends, no money, and would just become a crazy cat lady living in my own apartment." She is

unsure what she would want to study if she went to college and frequently finds herself reading travel blogs and fascinating places to travel.

Being in a small town has allowed Mary to play varsity sports, and she has played volleyball and soccer; she states, “I never would have made the team if I was in a larger community. I am not that great of a player.” Although she finds her small town confining, she also likes the slow place, quaint architecture, and knowing everyone in the town. She likes watching the Mississippi River, the trains rolling through town, and the state forests outside of town where she goes hiking and camping. She wishes there were more things to do and can find the slow pace boring at times. She states, “My town only has a McDonald’s and a Dairy Queen. Why can’t we get a decent pizza or Chinese or Mexican food.” She dislikes deer-hunting season because all the rednecks go hunting and you see dead deer in the back of their pickup trucks and see people cleaning them up in their backyards. Mary reports her main hobbies are reading, watching videos on Tik Tok, talking with her friends, and drawing/painting.

Mary grew up attending the local Methodist church, which has some adults who organize events for the community adolescents as an outreach to their youth group, but Mary does not participate in the youth group. She sees these people as naive and intrusive. She states, “If they knew who I really was they would be incredibly judgmental, so I get drug to church by my mother a couple of times a year and that is it.” She identifies as believing in God but thinks a lot of the religious aspects of her faith are garbage. She wants to know how a loving God of the universe can allow so much pain and suffering in the world.

Mary’s mother reports that Mary has always been independent and does what she does whatever Mary wants to do. She states, “No one can tell that child anything without a huge fight breaking out.” Mary’s mother admits she has largely given up trying to discipline Mary or

encouraging her to alter her substance use pattern because Mary's friends are more significant in her life than she is. Mother admits she is saddened by the gulf that exists between herself and Mary. She is hurt because Mary doesn't recognize the struggles and suffering that existed to create a safe and loving home for Mary. She becomes defensive and angry when discussing Mary's father and their relationship. She states,

Dave treats everyone like garbage, including both Mary and myself! What do you think it was like for me to have him just walk out and abandon me when Mary was 8! I don't know what Mary wants me to do about it—her relationship with her Dad is between her and him—there is nothing I can do about it.

Mary's mother confirms she doesn't want Mary to leave home because she has "no idea how college would be paid for. The military has gotten my oldest son; I'll be damned if they are going to get my daughter as well." The mother wants Mary to be able to control her substance use but also doesn't know how realistic this goal is because most of the teenagers drink and smoke marijuana, so she believes Mary will continue to engage in that behavior as well. Mother is afraid Mary will become pregnant before she gets married and will just settle down and live in their small town and be stuck as are so many of the women in town.

Case Study: Ryan (Young Adult, Male, Co-Occurring Mental Health)

Ryan is a 19-year-old male. Ryan and his brother were adopted by an older couple when Ryan was an infant, and little information is known about his young childhood years. He was diagnosed with developmental delays when he was 3 years old. His adoptive father passed away from a heart attack when Ryan was 6 years old, an event Ryan witnessed. He reports having strong memories of this event and found it to be terrifying, even though he didn't really understand what was happening. His adoptive mother is described as concerned and caring. She was a stabilizing factor in his and his brother's life. The family lived in a low-crime, healthy, family-focused, stable neighborhood. After his father passed away, his mother tried to convince her older daughter (our client's adopted half-sister) to adopt him; however, she refused for reasons that are unclear.

Neighbors report that Ryan was challenging to live near in the neighborhood, with reports of explosive anger followed by guilty apologies later. When Ryan was 11 years old, a neighbor sent him home for misbehaving and Ryan used a golf club to smash the neighbor's trailer. When he was 14, he was caught by a neighbor scooping fish out of the neighbor's fish pond. When confronted, Ryan was neither guilty nor surprised he had been caught stealing the fish. He also attacked his mother with a vacuum cleaner plastic hose and at 15 threw his mother against the wall. Ryan reports that he was often bullied during his elementary school days; however, he did have several friends, whom he has stayed connected to. Ryan's younger brother perceived Ryan as the preferred child in the family and is angry and resentful. This younger brother also admits to bullying Ryan.

As Ryan transitioned from elementary school to middle school, he was diagnosed with autism spectrum disorder by a school psychologist. Although this diagnosis was made, there was

resistance from his mother to accept this diagnosis, and few services were actually delivered in response. During middle school, reports increased of Ryan being disrespectful and having curfew violations. He usually dressed in a hoodie and would walk around the neighborhood with his head down. Several people in the neighborhood accused Ryan of being the cause of multiple break-ins in the neighborhood; however, there is very little evidence to support this accusation. During this time, Ryan's mother often turned to the police to help her keep him under control, but Ryan was never charged and does not have a legal record.

High school was a difficult time for Ryan. He usually presented as quiet and withdrawn, although he identifies as having had several friends he was close to and would hang out with. Teachers describe him as quiet and hardworking. Yet, Ryan would brag to his classmates that he had killed lizards, frogs, and snakes, as well as threatened people with physical harm. In his junior year, Ryan brought a knife to school, an incident that led to his expulsion. He then enrolled in another school and was making progress toward his high school diploma. He obtained a job as a cashier at the Dollar Store, where he was well liked by his coworkers and viewed as a hardworking and effective employee.

During high school, Ryan began to use cannabis. Initially, he would smoke in social situations. During his freshman year of high school, he smoked "once or twice a week." He discovered cannabis use decreased his anxiety and he felt better overall. This led to a significant increase in his use of cannabis during his sophomore and junior year. He is currently smoking cannabis at a frequency of 25 out of 30 days a month. The days he does not smoke are when he has run out of it and can't find it/get more. He denies dealing or engaging in criminal behaviors to obtain it, but nearly three fourths of his paycheck is used to acquire it. He reports he smokes three times a day when he smokes: once before school, once when he gets home, and then at

night to help him sleep. When he smokes, he is high for about 90 minutes, down significantly from the 3 to 4 hours he would feel high when he first started smoking. In the last year, Ryan has started to use alcohol. He reports he is drinking six to eight times a month (once or twice a week). When he drinks, he purposely drinks to become intoxicated. He drinks primarily hard liquor (his favorite is Jack Daniels), and he will drink between eight and 12 standard drinks. When he started drinking, he would need only two to three shots to become intoxicated. He experiences blackouts about 25% of the time when he drinks. Once he drank so much he passed out and his friends drew a mustache on his face and put a beard on his face made out of whipped cream. He says this was really funny because he didn't even know they were doing it. He has fallen several times and gotten banged up while drinking. He has driven a car when he was intoxicated several times and has ridden in a car with someone else driving who had been drinking. His mother does not like his use of alcohol, but he isn't moved by her concern to stop. He denies any signs or symptoms of alcohol withdrawal. He has taken Adderall about 10 times just to see if he liked it and because he was curious but has not used any Adderall in the last year and does think he will take it again. He denies any other drug use. Overall, Ryan views his substance use as pretty typical and common. Most of the males he knows uses in the same manner. He believes he could stop any time he wants to and does not see any reason to alter his substance use pattern.

In November 2017, his mother suddenly passed away from pneumonia. Following her death, Ryan experienced deep levels of grief and depression. He went to live with the parents of a friend who felt sorry for the difficulty Ryan faced by being orphaned at such a vulnerable stage of his life. This was not a great situation, and Ryan reports he is making plans to find another place to live by staying with another friend. Beyond working at the Dollar Store, Ryan has few

other options or thoughts about what to do next with his life. He has an interest in joining the military but, since his mother's untimely death, is unsure whether this is the right next step for him.

Case Study: William (Multiracial, Young Adult Male)

William arrives at the outpatient counseling office appearing tired and smelling like alcohol. He is 24 years old and of Filipino and African American background. William lives with his father and is seeking help as a result of an ultimatum that he is on his last chance: The next time he messes up, he'll be looking for a new place to live. His boss, too, has given him his last warning. His boss is happy with his work on the painting crew, but he's unhappy with William's habit of showing up late at least once a week. His boss has also wondered whether William has gotten high at lunchtime.

William graduated from high school and has attended college classes a couple of times but felt it was a bad match. He wants to go into the trades but has had a hard time committing to anything. He acknowledges, too, that it's difficult to get a good job without a clean drug test. He says he'd like to stop smoking long enough to get a clean test, and he's pretty sure he can do it on his own, without treatment. He just needs to be motivated enough to tell his friends "no" when they come around with a blunt to smoke.

As you talk with William about his teen years, he tells you about the intense anxiety he experienced. It began in elementary school, when he had a period of time during which he was afraid to go to school, afraid to sleep in his own room, afraid when his parents went out, and so forth. He was never quite able to just let go of his worries, although they decreased over time and he functioned pretty well throughout middle and high school.

William is a good-natured, friendly, and likable young man. He seems open and honest when you ask him how much he drinks and smokes and whether he uses other drugs. He drinks 3 to 4 days a week, sometimes just two or three beers, other times to the point of getting "really drunk." He smokes marijuana "not that often, just every once in a while," usually when someone

else suggests it. He's fairly healthy, which is a good thing since he has no health insurance. He likes his dad and has a pretty good relationship, except when his dad gets mad about his drinking and smoking. William has a few good friends that he's had since high school.

Appendix D
SBIRT Assessment

Screening, Brief Intervention, and Referral to Treatment

Multiple-Choice Questions

Please select the best response for each of the following questions.

1. Read the following case example and answer the question below.

Adam is 16 years old and needs a presurgical screening to repair an ACL he tore during a neighborhood football game 4 weeks ago. Which screening tool would be most appropriate?

- A. CAGE
- B. MAST
- C. AUDIT
- D. CRAFFT

2. Which of the following statements reflects the current evidence base for SBIRT (i.e., is *true*):

- A. SBIRT is most effective for patients who have unhealthy substance use but do not have a substance use disorder.
- B. SBIRT is most effective at intervening with patients who meet criteria for a substance use disorder.
- C. SBIRT is effective at identifying and intervening with patients who have depressive or anxiety disorders.
- D. SBIRT is more effective at addressing illicit drug use than tobacco or alcohol use.

3. Read the following dialogue and answer the question below.

Social Worker: Is it OK if I ask you a few questions about your tobacco, alcohol, and drug use?

Patient: Yes, that's fine.

Social Worker: During the past year, how often have you had at least five drinks of alcohol in one day?

Patient: I sometimes drink socially, but never that much.

Social Worker: How often have you used tobacco products in the past year?

Patient: Every day.

Social Worker: How often have you misused prescription drugs during the past year?

Patient: Never.

Social Worker: How often have you used illegal drugs during the past year?

Patient: Never.

Which of the following would be the best transition to screening the patient's tobacco use further?

- A. We need to talk about your tobacco addiction. Could you tell me more about it?
- B. Let's talk about your tobacco use.
- C. Can you tell me about your tobacco problem?
- D. You answered that you have used tobacco during the past year. Can you tell me more about that?

4. Read the following scenario and answer the question below.

Mr. Smith is a 40-year-old man with high blood pressure presenting for an annual appointment. During routine screening, you ask him about substance use. In prescreening, he

denies tobacco and illicit substance use, along with misuse of prescription drugs. He admits to using some alcohol. After you complete the alcohol screening questions, he says, “That’s enough questions about that.”

Which of the following is the best next step?

- A. Don’t pursue the topic of his alcohol use further because he doesn’t think he has a problem and doesn’t want help.
- B. Conduct a brief intervention.
- C. Ignore his resistance and continue with an assessment of his alcohol use because it is important.

5. What are the benefits of the AUDIT screening tool? (Check all that apply.)

- A. It can be used in primary care settings.
- B. A short version, which has only three questions, is available for use in primary care settings.
- C. It can be self-administered or administered by the provider.
- D. It requires only 2 to 4 minutes to complete.

6. Which of the following patients should be screened for substance use?

- A. Patients who display one or more “red flags”
- B. Patients with whom you have an established relationship
- C. Patients who may be prescribed potentially addictive medications
- D. All adolescent and adult patients

7. Mr. Jones reports alcohol use during the prescreening and scored a 4 when you administered the AUDIT. What should your next step be?
- A. Education and encouragement
 - B. Brief intervention
 - C. Brief treatment
 - D. Referral to treatment
8. Which of the following is *not* part of a brief intervention?
- A. Establish rapport
 - B. Enhance motivation
 - C. Elicit thoughts and provide feedback
 - D. Come to a shared understanding that the client has a substance use problem
9. The brief intervention step of enhancing motivation might include which of the following?
- A. Asking about the pros and cons of the substance use
 - B. Negotiating a plan
 - C. Asking the patient to rate their readiness to change on a scale of 1 to 10
 - D. A and C
10. The following could be a symptom of either alcohol or opioid withdrawal:
- A. Hallucinations
 - B. Insomnia
 - C. Hypothermia

D. Confusion

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT Assessment Quiz Answer Sheet

Multiple-Choice Questions

1. Read the following case example and answer the question below. (Competency 2: Engage Diversity and Difference; K, CAP, S)
 - A. CAGE
 - B. MAST
 - C. AUDIT
 - D. CRAFFT**

2. Which of the following statements reflects the current evidence base for SBIRT (i.e., is *true*): (Competency 4: Research Informed Practice; K)
 - A. SBIRT is most effective for patients who have unhealthy substance use but do not have a substance use disorder.**
 - B. SBIRT is most effective at intervening with patients who meet criteria for a substance use disorder.
 - C. SBIRT is effective at identifying and intervening with patients who have depressive or anxiety disorders.
 - D. SBIRT is more effective at addressing illicit drug use than tobacco or alcohol use.

3. Read the following dialogue and answer the question below. (Competency 6: Engagement; K, S)

- A. We need to talk about your tobacco addiction. Could you tell me more about it?
- B. Let's talk about your tobacco use.
- C. Can you tell me about your tobacco problem?
- D. You answered that you have used tobacco during the past year. Can you tell me more about that?**

4. Read the following scenario and answer the question below. (Competency 6: Engagement; K, CAP, S)

A. Don't pursue the topic of his alcohol use further because he doesn't think he has a problem and doesn't want help.

B. Conduct a brief intervention.

C. Ignore his resistance and continue with an assessment of his alcohol use because it is important.

5. What are the benefits of the AUDIT screening tool? (Check all that apply.) (Competency 7: Assessment, K)

A. It can be used in primary care settings.

B. A short version, which has only three questions, is available for use in primary care settings.

C. It can be self-administered or administered by the provider.

D. It requires only 2 to 4 minutes to complete.

6. Which of the following patients should be screened for substance use? (Competency 7: Assessment, K)

- A. Patients who display one or more “red flags”
- B. Patients with whom you have an established relationship
- C. Patients who may be prescribed potentially addictive medications
- D. All adolescent and adult patients**

7. Mr. Jones reports alcohol use during the prescreening and scored a 4 when you administered the AUDIT. What should your next step be? (Competency 8: Intervention; K, CAP, S)

- A. Education and encouragement**
- B. Brief intervention
- C. Brief treatment
- D. Referral to treatment

8. Which of the following is *not* part of a brief intervention? (Competency 8: Intervention, K)

- A. Establish rapport
- B. Enhance motivation
- C. Elicit thoughts and provide feedback
- D. Come to a shared understanding that the client has a substance use problem**

9. The brief intervention step of enhancing motivation might include: (Competency 8: Intervention K)

- A. Asking about the pros and cons of the substance use

B. Negotiating a plan

C. Asking the patient to rate their readiness to change on a scale of 1 to 10

D. A and C

10. The following could be a symptom of either alcohol or opioid withdrawal: (Competency 7: Assessment, K)

A. Hallucinations

B. Insomnia

C. Hypothermia

D. Confusion

SBIRT Postpractice Reflection

1. Can you think of any personal and/or professional experiences that influenced your understanding of this client?
2. Did issues related to diversity affect your approach with the client in this interview? Please give an example.
3. What did you find most challenging in dealing with this client, and what was your approach in dealing with this challenge?
4. How would you assess your degree of success in engaging and motivating the client during your interaction? What additional indicators might you use in the future?

SBIRT Postpractice Reflection

Please assign a rating on a scale of 1 to 5 for each question, with 5 = advanced competence and 1 = precompetence. The below rubrics are intended to assist in anchoring your rating.

1. Can you think of any personal and/or professional experiences that influenced your understanding of this client?

	Advance Competence	High Competence	Competence	Emerging Competence
Competency 1: Ethical and Professional Behavior CAP, V, S	Identifies prior personal and professional experiences and describes impact on cognition, affect, and skills applied. Recognizes strengths and limitations of application to current practice.	Identifies more than one prior personal or professional experience and relates it to at least two of the following: cognition, affect, or skills in current practice.	Identifies one prior personal or professional experience and relates it to cognition, affect, or skills employed in current practice.	Identifies prior personal or professional experience, but how influenced current practice is not clear. Or projects previous experiences onto current practice experience without discernment.

2. Did issues related to diversity affect your approach with the client in this interview?
Please give an example.

	Advanced Competence	High Competence	Competence	Emerging Competence
Competency 2: Engage Diversity and Difference K, CAP, S	Demonstrates comprehensive awareness of cultural, developmental, and demographic factors that may affect substance use, engagement, assessment, and intervention.	Identifies relevant cultural, developmental, or demographic factor and relates to at least two of the following: substance use, engagement, assessment, or intervention.	Identifies at least one relevant cultural, developmental, or demographic factor and effectively relates it to their practice approach.	Identifies one or no cultural, developmental, or demographic factor present but is unable to relate it to their practice approach.

3. What did you find most challenging in dealing with this client, and what was your approach in dealing with this challenge?

	Advance Competence	High Competence	Competence	Emerging Competence

Competency 1: Ethical and Professional Behavior K, CAP, V	Identifies more than one challenge and addresses it as a reflection of their personal or professional self. Clearly identifies strengths and weaknesses in their practice and recommend improved approach for future practice.	Identifies at least one challenge and relates it to their personal or professional self. Identifies at least one weakness in their practice.	Identifies at least one challenge and relates it to their personal and/or professional self (i.e., their cognitions, affect, or skills) in response to client.	Unable to clearly identify a challenge that relates to their own cognitions, affect, or skills. Or identifies a challenge but does not address it as a reflection of their personal or professional self.
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4. How would you assess your degree of success in engaging and motivating the client during your interaction? What additional indicators might you use in the future?

	Advanced Competence	High Competence	Competence	Emerging Competence
Competency 9: Evaluate Practice	Identifies multiple indicators of engagement and	Identifies more than one indicator of engagement	Identifies at least one indicator of engagement	Identifies one indicator of engagement but

K, CAP, S	motivation, including body language or tone, length of answers given, amount of change versus sustain talk, and shift of decisional balance.	and at least two MI-specific indicators of motivation (i.e., amount of change versus sustain talk, decisional balance).	(body language, tone, length of answers) and one MI-specific indicator of motivation (i.e., amount of change versus sustain talk, decisional balance).	no MI-specific indicators of motivation. Focus is still primarily on behavioral outcome versus process.
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