



Building Confidence and Preparedness In Social Work Practice: Addressing Complexities of Substance Use Disorders Through Asynchronous Virtual Simulations

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Abstract

Clinical social workers are key contributing professionals in the behavioral health workforce and have core responsibility to screen, assess, and treat mental illness and addiction. Virtual simulations are critical tools providing an experiential process to test the ability to engage and apply practice skills in a virtual environment before having to perform these skills with clients. They are confidence building mechanisms to enhance education and communication skills in schools of social work with specialized addiction focused programs. This study examined student outcomes resulting from simulation-based learning using virtual simulations. The virtual simulations were asynchronous where students engaged with virtual clients in various scenarios. Students completed pre and post surveys to facilitate researchers in measuring the impact of the simulations. Participants reported statistically significant higher levels of preparedness and confidence among practice skill areas including motivational interviewing, discussing behavioral health, conducting assessments, and engaging in brief interventions. Moving forward, it is vital to advocate for providing virtual simulations to build confidence and preparedness in clinical social work skills.

Keywords: Virtual Simulations, Substance Use Disorders, Student Confidence, Student Preparedness, Social Work Practice

Introduction

The role of clinical social workers involves a variety of specialty skills such as, establishing rapport, engagement, assessment, diagnostics,

treatment, and enhancing overall coping methods in the prevention of mental illness. The National Association of Social Workers provides specific skill sets for this specialty in clinical practice along with the Code of Ethics [1]. Schools of Social Work provide many practice courses at the foundation and the advanced levels to prepare social work practitioners as critical thinkers to address a myriad of clinical client scenarios. Virtual simulations provide a way to enhance student knowledge and competency-based skills in addition to traditional face-to-face classroom learning.

Several studies of late have explored the usefulness of virtual simulations in social work education as a helpful alternative especially during and subsequent to the COVID-19 pandemic [2-11]. Huttar and BrintzenhofeSzoc [12] conducted a systematic review of virtual simulations in social work education and found only seven relevant publications and that virtual simulations were utilized to teach direct practice skills. Baker and Jenney [13] found that various virtual simulations were useful to bridge learning gaps of traditional learning to effectively teach practice skills and Council on Social Work (CSWE) competencies.

The Council on Social Work Education Substance Use Disorders (SUD) curriculum provides guidance for MSW programs for specialized practice related to SUD [14]. Through support from Substance Abuse and Mental Health Services Administration (SAMHSA) Practitioner Education (PracEd) Grant, multiple universities have been introduced to specialized SUD curricula including virtual simulations to enhance (MSW) graduate social

work education [15]. The specialized curriculum incorporated CSWE Educational Policy and Accreditation Standards (EPAS) generalist practice competencies and serves as a resource for more than 90 schools of social work across the country. As part of the implementation of PracEd Grant, virtual simulations were introduced and piloted to provide alternative learning of evidence-based practice skill building.

Kognito is a company that housed virtual simulations providing real-life client encounters with interactive practice with avatars in an electronic environment. One of the virtual simulations introduced to PracEd grantees was Kognito's virtual simulation designed to harness the power of interactions with virtual humans in a safe and versatile digital environment. Within the Kognito simulation, learners were engaged with a virtual human with a distinct personality, set of beliefs, engagement level, and an issue with substance misuse. Prior to meeting the virtual client, an interactive didactic lesson provided a synopsis of the case, review of clinical knowledge, and an illustration of evidence-based communication techniques needed to successfully facilitate a clinical scenario. The Kognito [16] virtual simulation was delivered as an asynchronous simulation after initial synchronous introduction of the simulation was provided to learners.

The virtual simulations are important because they provide an experiential process to apply skills and test student ability to engage, establish rapport, screen, assess, and practice intervention skills in a virtual environment before having to perform these skills with human clients. It is a confidence-building mechanism put in place to enhance education and interpersonal communication skills in schools of social work with specialized addiction-focused programs. This study examined student outcomes resulting from simulation-based learning using virtual simulations.

Methods

Virtual Simulation Intervention

After the study was approved with the lead author's institutional review board (IRB), faculty worked to involve social work students with the virtual simulations. Initial funding for Kognito simulations was provided via SAMHSA PracEd grant with supplemental funding for subsequent virtual simulations approved through technical budget funds at an average rate of \$50 per student. The simulations were part of classroom experiences with class sizes ranging from 20-25 per semester across specific social work courses. In order to engage with the simulation, students were instructed to click a link provided to enter the Kognito platform and required no additional equipment.

Researchers engaged over 150 student participants in virtual simulations from 2021 to 2023. Designed by Kognito [16], these simulations leveraged virtual human interactions to provide a safe and adaptable digital learning environment for evidence-based practice skill-building. Within the simulations, learners interacted with a virtual client, each with a distinct personality, belief system, and substance misuse challenge. Before engaging with the client, students completed an interactive didactic lesson that introduced the case, reviewed clinical knowledge, and demonstrated evidence-based communication techniques essential for navigating the scenario. Following a synchronous introduction to familiarize students with the platform and learning objectives, the Kognito asynchronous simulation was introduced.

Each of the three Screening and Brief Intervention (SBI) simulations took between 70-90 minutes for students to complete. The first simulation centered on SBI with adults specifically (SBI₁), the second (SBI₂) and third simulation focused specifically with the adolescent population with the focus on adolescents with comorbidity (SBI₃). Post-test surveys were given to students immediately after completing the simulation. Faculty placed these simulations within courses across the MSW curriculum. SBI with adults (SBI₁) was part of Human Behavior in the Social Environment course during

the course content that focused on social work practice with adults. This course is offered in the first semester for MSW students before they are placed in their internship/practicum in the community. SBI with adolescents (SBI₂) was part of a course entitled, Introduction to Substance Use Disorders and Addictions, that introduced students to social work practice with substance use disorders/addictions. SBI with adolescents and comorbidity (SBI₃) was offered as part of a course entitled, Assessing and Treating Eating Disorders, Exercise and Food Addictions. The (SBI₃) simulation was by design a more complex simulation to engage in with comorbidity and was placed in a course offered later in the curriculum than the other two simulations.

Research Questions

This study investigated the impact of asynchronous virtual simulations on student preparedness and confidence in substance use specific behavioral health interventions. Specifically, the following research questions were addressed:

Q1: Are the samples across the three simulations comparable in terms of demographic and baseline characteristics?

Q2: Does each simulation result in significant gain in student preparedness and confidence from pre-to post-test?

Q3: Do the simulations differ in effectiveness, with one producing greater improvements than the others?

Outcome Measures

Preparedness. Four questions were utilized to identify changes in levels of preparedness related to screening patients with behavioral health concerns using validated instruments, initiating a conversation with a patient about their behavioral health, using motivational interviewing to motivate a patient to seek behavioral health treatment, and scheduling follow-up visits or referrals with their patients. These questions were asked on a 5-point Likert scale from very low to very high.

Confidence. The four questions were also used to capture a shift in confidence levels of students in relation to screening for behavioral health concerns, initiating conversations about behavioral health, motivational interviewing techniques, and confidence in scheduling follow-ups or referrals with clients. Confidence was measured via 5-point Likert scaling from strongly disagree to strongly agree.

Data Analysis

To understand the comparability of the three samples, independent samples t-tests and chi-square tests were generated. Paired t-tests were utilized to measure the changes in pre-post survey questions about preparedness and confidence. Researchers also analyzed the differences between the simulations using ANOVA and Tukey Pairwise comparisons.

Results

Asynchronous Virtual Simulation Descriptives

A total of 158 students completed the pre-tests across all simulations, with 95 completing both the pre-test and post-test simulation tests. A total of 31 students completed the SBI₁ pre and post-test, 30 students completed the SBI₂, and 34 completed the SBI₃ simulation. Each simulation's samples shared similar demographics with around 85% of each sample representing females, largely identifying as heterosexual (70%). With regards to race and ethnicity, 97% of SBI₁ students identified as White and 13% as Hispanic/Latinx. Among SBI₂ students, 67% identified as White, 10% identified as "mixed race," 7% as Black or African American, 7% as Hispanic/Latinx, and 3% as Asian. In SBI₃, students largely identified as White (88%), 6% as Hispanic/Latinx, and 3% as Black or African American.

Students were an average of 26.87 years old (SD=7.96). There was not a significant difference in age across the simulation groups (SBI₁: M=26.70, SD=5.87; SBI₂: M=26.5, SD=10.91; SBI₃: M=27.36, SD=6.39; $p>0.05$). At the post-test, students reported an average of 1.65 years of experience in the social work field (SD=1.47). The only

simulation participants who had statistically different levels of experience were the SBI₃ sample ($m=2.03$, $SD=1.51$), which had significantly more experience than the SBI₁ sample ($t=-2.53$, $m=1.17$, $SD=1.23$, $p=0.014$), but not the SBI₂ group ($m=1.73$, $SD=1.55$, $p>0.05$).

Previous Trainings with Screenings and Brief Interventions

The samples also differed in how much previous training they had received in substance use screening with brief interventions and mental health screenings with brief interventions prior to completing the simulations. Overall, about 71.43% of the students engaged with mental health screenings ($SD=14.09$) and about 54.98% had previous training in substance use screenings and brief interventions

($SD=24.44$). However, students in the SBI₁ simulation had significantly lower levels of substance use training (26.67%) than SBI₂ (71%) and SBI₃ samples (66.67%; $X^2=15.58$, $p=0.0004$). An overall statistically significant difference between the sample's experience with mental health screenings was identified ($X^2=6.43$, $p=0.040$); however, the significance was found only in the relationship of SBI₃ (84.85%) to SBI₂ (56.67%) with SBI₃ having statistically higher levels of experience compared to SBI₂ sample's experience ($p=0.024$). No significant difference between the other simulations and SBI₁ sample's experience with mental health screenings (70%) were identified. A visual representation of these relationships is seen in Figure 1.



Figure 1. Levels of previous training experience across simulation samples.

Client Interaction on Weekly Basis

Most SBI₁ students reported that they were not seeing clients at the time of the simulation (96%). Of the few who did, they reported seeing an average of 13 clients on a weekly basis ($SD=3.61$). Additionally, these students screened around 12.33 clients ($SD=2.52$) for behavioral health concerns per week and engaged in brief interventions for behavioral health with an average of 13 clients ($SD=3.61$) and made 4.67 weekly referrals ($SD=1.53$) to additional behavioral health treatment or support services. About 89% of the students in SBI₂ reported not seeing clients on a weekly basis. Of those who did, they screened around 7.75 clients ($SD=5.91$) for behavioral health concerns per week. They engaged in brief interventions, screenings, and referrals with an average of 6.5 clients ($SD=4.12$). Students engaged with the SBI₃ simulation also reported low levels of weekly client services (89%). The sample saw an average of 9.04 clients on a weekly basis ($SD=6.45$), performed around 3.96 ($SD=4.89$) screenings, 5.8 brief interventions ($SD=4.74$), and around 3.64 referrals ($SD=4.65$) per week.

Overall, there were significant differences between the simulation groups across a few relationships identified through t-tests and Chi-square analyses. SBI₁ students engaged with significantly more clients per week than SBI₃, but not SBI₂ ($t=3.09$, $p=0.003$). SBI₁ also screens and engages with significantly more clients than SBI₂ ($t=6.64$, $p<0.001$), but not significantly more than SBI₃. SBI₂ students, however, reported significantly more weekly referrals than

SBI₁ but not SBI₃ students. Students across all three simulations reported similarly low levels of currently working with clients (SBI₁=96% vs SBI₂=89% vs SBI₃=89%; $X^2=4.13$, $p=0.13$).

Changes in Preparedness and Confidence

Preparedness

Four questions were utilized to capture a student's perceived preparedness to address SBI following the virtual simulation. Results of question level changes are available in Table 1. An ANOVA statistical test identified significantly different gains in scores of preparedness ($F=22.28$, $p=0.0003$). Tukey Pairwise comparison revealed that students in the SBI₁ improved the most in their level of preparedness with a mean gain score of 1.32. Both SBI₂ (0.52) and SBI₃ (0.48) showed positive score changes, but with lower gains than SBI₁, as seen in Figure 2.

Confidence

As seen in Table 2, the four questions used to capture a shift in confidence levels of students revealed strengthening confidence in almost all areas for most simulations. An ANOVA statistical test identified significantly different gains in scores of confidence ($F=9.32$, $p=0.002$). Tukey Pairwise comparison revealed that students in the SBI₁ gained higher levels of confidence (0.95 mean gain score) than students in SBI₂ (0.37, $p<0.05$) and students in SBI₃ (0.37). Both SBI₂ and SBI₃ showed increased levels of confidence at the same mean gain score.

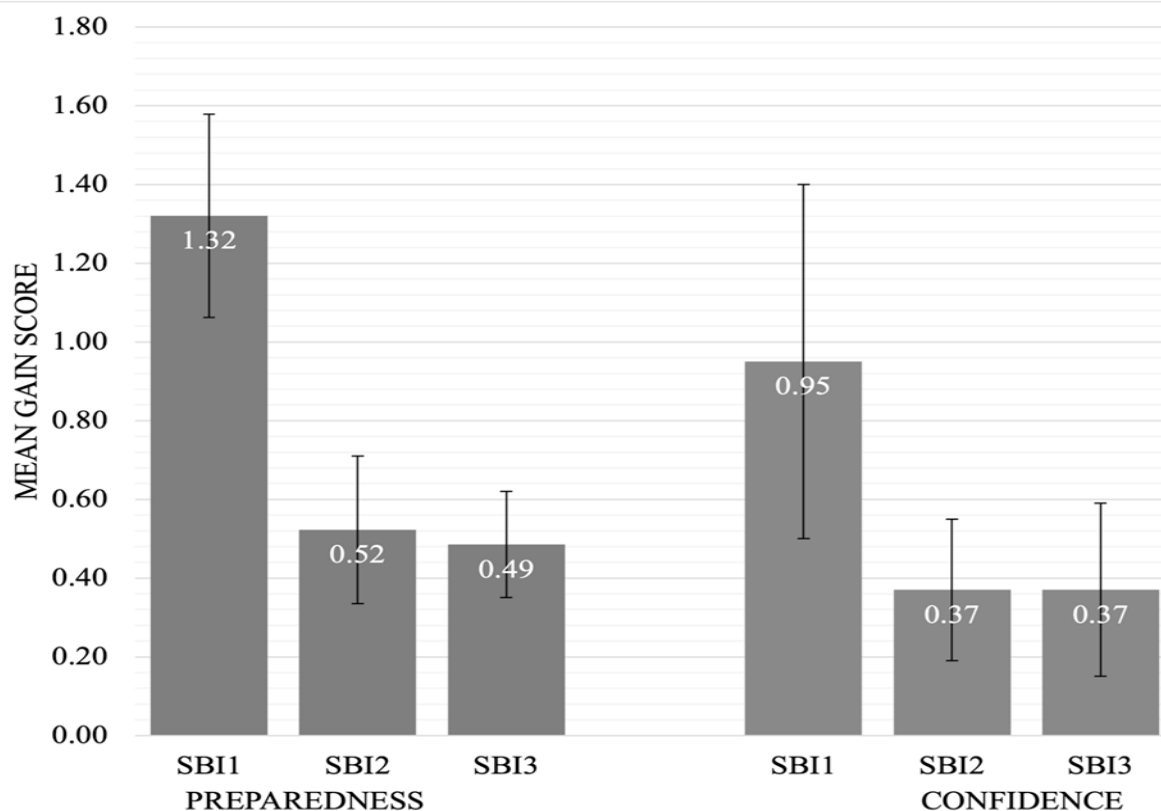


Figure 2. Mean Gain Score Comparisons with Error Bars

Discussion

Key Findings

Students showed statistically significant increases in preparedness and confidence across all three simulations. This allowed researchers to use the strongest approach of assessing gain scores to understand which simulation was most effective or if all were effective, regardless of simulation type. Results reveal that students who engaged with SBI₁ gained significantly higher mean scores than SBI₂ and SBI₃. SBI₂ and SBI₃ were both effective in increasing preparedness and confidence, but at a lesser impact than SBI₁. It is possible that this difference in gain scores is due to SBI₁'s sample starting the simulations with less experience than the other groups. Students participating in the first simulation were in their first semester of the MSW program and had not yet entered into their internship/practicum. Another possible explanation could be that perhaps it is easier to gain confidence in a simulation with an adult client compared to an adolescent client like actual adult vs. adolescent interactions.

Interpreting Sample Comparability

The comparisons of sample similarities indicated that the groups were not fully identical as some groups showed lower levels of pre-test scores (SBI₁) and different levels of prior substance use and mental health training. The samples were not significantly different in age nor were they seeing clients at different rates. Students in SBI₁ started the simulation with significantly lower levels of previous training than the other two groups. Future research should control these variables with a larger sample size to understand the nuances of the effects across samples.

Moreover, since the student participants were similar, they represent a homogenous group. This can help with understanding that each simulation improved the impact on student confidence and preparedness to address substance use concerns across adult and adolescent virtual clients.

Comparison with Existing Literature

It is vital for social work practitioners to be skilled in clinical interviewing, engagement, assessment, and brief intervention with clients. For the Kognito virtual simulations, participants reported a major shift in levels of preparedness when leveraging Motivational Interviewing techniques to discuss mental and behavioral health. Students improved significantly in preparedness and confidence across all three virtual simulations, particularly with Motivational Interviewing (MI) and clinical skills. Anxiety about applying these skills in real-world settings decreased, showing the value of practice in a safe virtual environment. Moreover, participants reported high levels of satisfaction with using virtual simulations to enhance their learning and preparation for their careers.

The results from this study align with prior studies demonstrating virtual simulations are effective in social work education [12, 13]. Thus, this study supports the idea that virtual SBI-focused simulations are effective in clinical skill building and lowering anxiety of participants. Virtual simulations are important in clinical social work practice classrooms because they can boost student confidence levels, give students the ability to practice with an electronic human being without the risk to harm in a client scenario, and raise clinical skills in needed areas of work within the clinical specialty field of substance use/addictions.

The overall strength of providing these virtual simulations is the focus on brief screening and intervention gives targeted relevant practice with real-world applications. Limitations of this study include a small sample size and reliance on self-reported data interpreted with caution. In addition, some students having prior knowledge or experience with SBI techniques may have influenced their starting points.

Implications for Clinical Social Work

Virtual simulations can enhance clinical social work education as they are practical, relevant, and effective in skill building and

lessening anxiety. As per the PracEd SAMHSA grant [15], we interspersed virtual simulations in several MSW courses to expand the integration of substance use disorder evidence-based education into the standard education of future professional social workers. The simulations directly address CSWE core competency areas and bridge the gap between theory and clinical practice. For social work students, the SBI simulations build confidence, can reduce anxiety in approaching clients in behavioral health settings. Also, students gain knowledge and experience in having challenging conversations in a minimal risk and high reward virtual environment.

Graduates from schools of social work that provide simulation training are prepared to meet workforce demands in behavioral health, particularly for clinical skills such as brief screening and intervention specifically Motivational Interviewing. Virtual simulations address gaps in learning and ensure students are prepared and ready to handle real-world scenarios in social work practice.

Continued support from funding sources (e.g. SAMHSA or internal university funds) is critical to sustaining and expanding simulation programs. Advocacy for policies that prioritize simulation-based learning can help ensure schools of social work have the resources to implement these tools effectively and consistently.

Building on the success of these virtual simulations there are many other areas to consider exploring within social work education. For example, virtual simulations could provide students in policy coursework a unique and interactive way to practice discussion points for meetings with legislators or public speaking on key issues. Similarly to the clinical simulations, these simulations would provide a safe, controlled environment where students can hone their communication and negotiation strategies and therefore build confidence. Fostering leadership development is another possible arena for considering the use of virtual simulations. Simulations could be designed for students to enhance their supervision skills and build their decision-making abilities. In addition to preparing students, virtual simulations are invaluable for continuing education, where professionals can explore new areas of practice and develop new skills. Virtual simulations may assist students and professionals build competence, improve their readiness for complex tasks, and gain the confidence needed to navigate real-world challenges effectively in safe spaces.

In addition, in terms of equity in social work education, virtual simulations help to level the playing field, especially for students with barriers to traditional internship/practicum placements. Where some students are placed in clinical social work placements with ample opportunity to experience direct clinical social work practice with clients dealing with substance use disorders/addictions and various behavioral health concerns, others may not have these rich experiences. Virtual simulations along with direct access to feedback from social work professors in the classroom can ensure access to technology and support to ensure all students can benefit more equitably from clinical skill building.

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Conflicts of Interest: The author reports there are no competing interests to declare.

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Please indicate your preparedness to...	SBI with Adults						SBI with Adolescents						SBI with Adolescents with Comorbidity					
	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value
Screen patients for behavioral health concerns using validated instruments	2.17	3.68	1.5	69.21	1.2	***	2.94	3.7	0.76	25.66	1	***	3.39	3.94	0.55	16.25	0.75	***
Initiate a conversation with a patient about their behavioral health	2.88	3.87	0.99	34.41	0.74	***	3.33	3.8	0.47	14.00	0.82	***	3.56	4	0.44	12.33	0.67	***
Use motivational interviewing to motivate a patient to seek behavioral health treatment	2.4	3.94	1.54	63.98	1.53	***	3.22	3.77	0.54	16.90	0.88	***	3.34	3.97	0.63	18.83	0.79	***
Schedule a follow up visit or refer patients to additional behavioral health treatment or support services	2.79	4.03	1.25	44.70	0.7	***	3.56	3.87	0.31	8.75	0.59	**	3.8	4.12	0.31	8.22	0.43	*

Table 1. Students' Level of Preparedness across SBI Simulations

All p-values were significant ($< .001$)

.2 indicates small effect size; .5 indicates medium effect size; .8 indicates large effect size

Please indicate how much you disagree/ agree with the following statements	SBI with Adults						SBI with Adolescents						SBI with Adolescents with Comorbidity					
	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value	Pre Mean	Post Mean	Gain Score	% Change	Effect size	P-value
I feel confident in my ability to screen patients for behavioral health concerns using validated instruments	2.86	4.03	1.17	40.84	0.97	***	3.39	3.97	0.58	17.05	0.66	**	3.78	4.12	0.34	8.92	0.67	***
I feel confident in my ability to initiate a conversation with a patient about their behavioral health	3.44	4.1	0.66	19.15	0.75	***	3.72	3.97	0.24	6.57	0.33	n.s.	3.88	4.24	0.36	9.21	0.42	*
I feel confident in my ability to use motivational interviewing to motivate a patient to seek behavioral health treatment	2.9	4.03	1.13	38.85	1.27	***	3.56	3.87	0.31	8.75	0.5	**	3.71	4.18	0.47	12.65	0.79	***
I feel confident in my ability to schedule a follow up visit or refer patients to additional behavioral health treatment or support services	3.37	4.19	0.82	24.44	0.74	***	3.75	4.1	0.35	9.33	0.7	***	4.02	4.32	0.3	7.43	0.47	*

Table 2. Students' Confidence across SBI Simulations

.2 indicates small effect size; .5 indicates medium effect size; .8 indicates large effect size