PRIME GRANT ASSESSMENT AND DATA (2022-2023)

Executive Summary and Recommendations

In this second year of the PRIME grant, the leadership team has been very successful at meeting its goals and objectives. Quantitative and qualitative analyses provide evidence that PRIME participants find the trainings to be of value and are expanding their knowledge and skill set. There has also been good progress towards enhancing the curriculum, especially with the number of additional courses embedding PRIME topics and content. Below are some key recommendations and items to keep an eye on as the PRIME grant moves into its second year.

Recommendation:

- *Communication and Community Faculty members, in particular, expressed feeling disconnected from the larger PRIME team members and participants. Several faculty members also indicated a wish for feedback on how well they've embedded PRIME topics and content into their courses. It should be noted that many faculty members who shared this concern are also adjunct faculty members. The PRIME grant's goals are many, and there are many constituents – including faculty, students, and community partners. At this scale, it can be very difficult to bring everyone together and build a sense of community. We recommend the following action items (if not already implemented):*
    - *A bi-weekly email update sent out to everyone – this email might also highlight a faculty, student, and community partner each week;*
    - *Opportunities for faculty members embedding PRIME topics and content to gather together and discuss their pedagogical methods;*
    - *Sharing of evaluation findings with the PRIME participants so that they have a sense of how things are progressing along.*

Items to Keep an Eye On:

- *Curriculum There is excellent progress towards enhancing the curriculum – especially with the number of courses which have embedded PRIME topics and content. This is simply a note that the PRIME team should keep an eye on developing the inter-disciplinary three course electives, as that is slightly behind the proposed deadline.*

- *Representation and Underserved Areas Going into the grant, the PRIME team was already very well-aware that diversifying the student participants was going to be a challenge. There has been some good progress made this second year, but there will need to continued progress in the third year. In addition, while good progress has been made towards placing the students at internship organizations that work in underserved areas, there will need to be more continued progress during the third year.*

PRIME GRANT ASSESSMENT AND DATA (2022-2023)

Goal #1

Objective:

Strengthen the recruitment of students from underrepresented groups in the MS in Clinical Psychology and MSW programs

Measure:

(1) Annual data on number of applicants, accepted students, and enrollments in each PRIME program
(late December/late May annually)
(2) Semester-to-semester retention data for each PRIME program (late December annually)

Outcome:

(1) An increase in total enrollments from underrepresented groups by 15 students (from a 2020/2021 baseline of 36 students)

Data:

(1) Out of 22 SOWK students in Fall 2022, there was 100% retention rate.
- 18 students identified as female and 4 students identified as male.
- 18 students identified as White, 2 identified as African American, 1 identified as Asian, and 1 identified as a person of color.
- 22 students identified as non-Hispanic.

Out of 7 PSYC students in Fall 2022, there was 100% retention rate.

- 6 students identified as female and 1 student identified as male.
- 6 students identified as White and 1 student identified as bi-racial/multi-racial.
- 6 students identified as non-Hispanic and 1 student identified as Hispanic.

Was outcome met?

As of the end of the Fall 2022 semester, outcome #1 was not yet met. However, there is very good progress towards that goal. For the two cohorts spanning 2021-2022 and 2022-2023, we have a total of eight students who identify as students of color, and four students who identify as Hispanic.

- There are five SOWK students who self-identify as persons of color.
- There is one SOWK student who self-identify as Hispanic.

- There are three PSYC students who self-identify as persons of color.
- There are three PSYC students who self-identify as Hispanic.

The plan is to slowly diversify the student cohorts over the four years of the grant, as the PRIME team has already anticipated that this particular goal would be a challenge.

The grant leadership team is making good progress towards increasing total enrollments from underrepresented groups by 15 students (from a 2020/2021 baseline of 36 students).

Goal #1

Objective 1(A):

Develop new marketing materials to promote MS in Clinical Psychology and MSW programs

Measure:

(1) Qualitative description of new materials (late May / early June 2022)
(2) Interviews with project leaders about key facets of new strategy (late January / early February 2022)

Outcome:

(1) A new promotional video for each PRIME program, several new print materials, new social media pages

(Already completed and met during 2021-2022)

Goal #1

Objective 1(B):

Present informational programs to audiences at MU and in the surrounding community, including students from underrepresented groups

Measure:

(1) Number of presentations delivered each year (Late December 2022 / Late May 2023)
(2) Information about groups receiving the presentations (Late December 2022 / Late May 2023)
(3) Number of people present at each presentation (Late December 2022 / Late May 2023)

Outcome:

(1) Present PowerPoint presentation to at least 500 additional prospective students each year

Data:

For outcomes #1 and #3: For Fall 2022,

87	Initial Youtube Video
111	New Youtube Video
138	Kaltura Views
16	Field Orientation Video
30	Presentations to MSW students
24	Field Orientation Sessions
8	MSW Informational Session
6	Individual MSW Meetings
16	Potential Clinical Psychology Students
5	Social Work Undergraduate Open House

	441

For Spring 2023,

46	Initial YouTube Video
95	New YouTube Video
13	PRIME Open House
13	PRIME Open House Video
12	MSW Open House and Info Sessions
40	MSW Orientation

219

Was Outcome Met?

- The team **met its goal** of making informational presentations to at least 500 students a year **during 2022-2023** (a total of 660).
- It is unclear whether there are data on whether these presentations were made to members underrepresented groups. Once again, we should consider whether there needs to be more data strategically collected on this demographic variable.

Goal #2

Objective:

Expand the number of community partners and clinical internship sites, with a focus on new sites in underserved areas

Measure:

1) Number of active community partners and clinical internship sites (At the beginning and end of every academic semester – 4 times a year)

Outcome:

(1) An additional 2 community partners (10 in total by the end of the project, at least 7 in underserved areas)

Data:

New Sites for MSW Program (For Fall 2022)

New PRIME Sites	County	Medically Underserved	Mental Health HPSA
Bethany Children's Home	Berks	No	No
High Road School of York	York	No	No
Leg Up Farm	York	No	No
Matters of the Heart Counseling	Lancaster	No	No
Student Wellness Center at F&M College	Lancaster	No	No
The Academy	Montgomery	No	No

New Sites for Clinical Psychology Program (Fall 2022)

New PRIME Sites	County	Medically Underserved	Mental Health HPSA
Advanced Counseling and Testing Solutions, LLC	Berks	No	No
Arrow Counseling Services	York	No	No
Berks Counseling Services	Berks	Yes	Yes
Encanto Wellness	Lancaster	No	No

Paragon Behavioral Health	Lancaster	No	No
Penn State Health Sleep Research and Treatment Center	Dauphin	No	No
Wellspan York Hospital- Behavioral Health Unit	York	No	Yes

Was Outcome Met?

- For the MSW program, as of May 2023, there were six new community partners, none of which are in underserved areas, nor in a mental health HPSA.
    - For 2021-2022, there were eight new community partners, one of which is in an underserved area, and one is an in a mental health HPSA.
- For the Clinical Psychology program, as of May 2023, there were seven new community partners, one of which is in an underserved area and in a mental health HPSA.
    - For 2021-2022, there were nine new community partners, one of which are in a medically underserved area, and one of which is in a mental health HPSA.

To summarize, as of May 2023, the count is as follows:

Table 1 **Number of Active Community Partners and Clinical Internship Sites**

MSW Program

Year	Number of New Sites	Medically Underserved	Mental Health HPSA
2021-2022	8	1	1
2022-2023	6	0	0
TOTAL	**14**	**1**	**1**

Clinical Psychology Program

Year	Number of New Sites	Medically Underserved	Mental Health HPSA
2021-2022	9	1	1
2022-2023	7	1	2
TOTAL	**16**	**2**	**3**

The PRIME program has already met the goal of adding at least 10 new community partners through the grant time period.

The program has also added three partners located in medically underserved areas and four partners in mental health HPSAs.

The program will need to add four more partners located in medically underserved areas to meet the grant goal.

Goal #3

Objective

Better prepare MU faculty and staff at partner facilities to integrate technology, including telehealth services, into the curriculum and the provision of services and to better serve patients from underrepresented groups

Measure:

1) Interviews with MU instructional staff (Mid/late December 2022 and Mid/late May 2023)

Outcome:

(1) An additional 6 courses in each program will integrate telehealth services
(2) 8 courses will integrate cultural competency
(3) 100 staff at community partner organizations will participate in training

Data:

Courses

For Fall 2022,

- Three additional SOWK courses have integrated telehealth and/or cultural competency into their curriculum.
    - SOWK 602: Behavioral Health
    - SOWK 610: Advanced Micro Practice and Assessment
    - SOWK 620: Advanced Practice with Groups and Families

- Four additional PSYC courses have integrated telehealth and/or cultural competency into their curriculum.
    - PSYC 631: Psychotherapy and Intervention Skills
    - PSYC 633: Systems of Psychotherapy
    - PSYC 635: Psychopathology
    - PSYC 636: Cognitive Therapy

For Spring 2023,

- Two additional PSYC courses have integrated telehealth and/or cultural competency into their curriculum.
    - PSYC 630: Group Therapy
    - PSYC 637: Theories of Family Dynamics

Including courses from the 2021-2022 academic year,

- Six SOWK courses have integrated telehealth and/or cultural competency into their curriculum.

- Nine PSYC courses have integrated telehealth and/or cultural competency into their curriculum.

Community Partners

- 54 staff at community partner organizations participated in the Fall 2022 interprofessional collaboration webinar training.
- 56 staff at community partner organizations participated in the Fall 2022 supporting children with behavioral health needs webinar training.
- 59 staff at community partner organizations participated in the Spring 2023 trauma informed communities webinar training.
- 48 staff at community partner organizations participated in the Spring 2023 cultural competency hybrid training.

Was Outcome Met?

For outcome #1 – **100% of target number of courses have integrated telehealth services**

For outcome #2 – **over 100% of target number of courses have integrated cultural competency**

For outcome #3 – **has exceeded goal for 2022-2023 – 217 staff at community partner organizations have participated in webinar training for this year**

Goal #3

Objective 3(a)

Conduct needs assessment across all community partners and clinical internship sites

Measure:

(1) Summary of needs assessment (Mid/late November/December 2022 and mid-late April/May 2023)
(2) Interviews with staff at community partners (Mid/late January/February 2023 and mid-late June/July 2023)

Outcome:

(1) A written report on the constraints faced by local organizations servicing the behavioral health needs of the public

Data:

- See Appendix A for written report

Was Outcome Met?

For outcome #1: completed (see Appendix A)

Goal #3

Objective 3(b)

Conduct professional trainings on best practices for teaching about telehealth, cultural competency, and youth violence in the classroom

Measure:

(1) Number of workshop participants from MU and from community partners
(2) Pre- and post-surveys of all workshop participants (scales administered prior to and post-training; tracked at the end of each training)

Outcome:

(1) All faculty and staff complete trainings on telehealth and cultural competency and express greater confidence in teaching both subjects
(2) 50% of PRIME partners attend trainings

Data

Measure 1

- 16 MU faculty and/or staff, 63 MU students, and 54 staff at community partner organizations participated in the Fall 2022 interprofessional collaboration webinar training.
- 14 MU faculty and/or staff, 49 MU students, and 56 staff at community partner organizations participated in the Fall 2022 supporting children with behavioral health needs webinar training.
- 12 MU faculty and/or staff, 49 MU students, and 59 staff at community partner organizations participated in the Spring 2023 trauma informed communities webinar training.
- 14 MU faculty and/or staff, 43 MU students, and 48 staff at community partner organizations participated in the Spring 2023 cultural competency hybrid training.

Measure 2

- Assessment of Fall 2022 interprofessional collaboration webinar training (see Appendix B)
- Assessment of Fall 2022 supporting children with behavioral health needs webinar training (see Appendix C)
- Assessment of Spring 2023 trauma informed communities webinar training – quantitative analysis is complete (see Appendix D)
- Assessment of Spring 2023 cultural competency webinar training (see Appendix E)

Was outcome met?

For goal #1, yes, overall, faculty and staff expressed greater confidence in knowledge about and teaching the subjects.

For goal #2, the outcome was met.

> **For the Fall 2022 training on interprofessional collaboration, 18 out of 21 MSW PRIME site partners attended (85.7%) while for Clinical Psychology, 4 out of 8 site partners participated (50.0%).**
>
> **For the Fall 2022 training on supporting children with behavioral health needs, 19 out of 21 MSW PRIME site partners attended (90.5%) while for Clinical Psychology, 5 out of 8 site partners participated (62.5%).**
>
> **For the Spring 2023 training on trauma informed communities, 16 out of 21 MSW PRIME site partners attended (76.2%) while for Clinical Psychology, 6 out of 8 site partners participated (75.0%).**
>
> **For the Spring 2023 training on cultural competency, 18 out of 21 MSW PRIME site partners attended (85.7%) while for Clinical Psychology, 7 out of 8 site partners participated (87.5%).**

Goal #4

Objective

Develop more interprofessional, experiential, and applied learning experiences in the curriculum

Measure:

(1) Qualitative comparison of curriculum before and after the project (PRIME Leadership Team is handling this part of data collection and will share their information with evaluation team at each semester's meeting.)
(2) Survey all program students before the program, each year of the program, and at the conclusion of the program (Throughout the year, report due in early June of each year)
(3) Team-based survey of SOWK students in the fall and PSYC students in the spring, along with a post-survey of all students at the end of the spring semester

Outcome:

(1) The students in each program report a high level of engagement with the subject matter and sense of preparedness

Data:

Completed:

- Pre- and Post-Test Analysis of PRIME survey data (see Appendix F)
- Team-Based Model Survey Analysis of PRIME students (see Appendix G)

Was Outcome Met?

For outcome #1 – met

- PRIME participants reported improvements on all four PRIME survey scales, with all the improvements being statistically significant.
- A majority of the PRIME student participants also reported that they could see the utility of using a team-based model, and expressed nuanced appreciation for this approach.

Goal #4

Objective 4(1)

Develop more interprofessional, experiential, and applied learning experiences in the curriculum

Measure:

(1) Create an interdisciplinary three-course elective sequence (mid-December 2022 / mid-May 2023)
(2) Interviews with MU faculty (mid-December 2022 / mid-May 2023)

Outcome:

(1) 3 new elective courses available to students in each program

Data:

Thus far, one course has been created (PSYC 587/639: Existential and Humanistic Therapies).

Was Outcome Met?

For outcome #1: ongoing – 1 out of 3 courses has been created in PSYC

Goal #4

Objective 4(2)

Embed telehealth, cultural competency, and resources for addressing youth violence throughout the curriculum

Measure:

(1) Number of revised courses (mid-December 2022 / mid-May 2023)
(2) Interviews with MU faculty (mid-December 2022 / mid-May 2023)

Outcome:

(1) At least 4 revised courses in each program

Data:

For 2022-2023, the following additional courses embedded PRIME content and topics

- SOWK 602: Behavioral Health (Spring 2023)
- PSYC 631: Psychotherapy and Intervention (Fall 2022 and Spring 2023)
- PSYC 633: Systems of Psychotherapy (Fall 2022)
- PSYC 635: Psychopathology (Fall 2022)
- PSYC 630: Group Therapy (Spring 2023)
- PSYC 636: Cognitive Therapy (Fall 2022)
- PSYC 637: Theories of Family Dynamics (Spring 2023)

Including 2021-2022, this means that as of August 2023, 3 courses in SOWK and 9 courses in PSYC have embedded PRIME content and topics

Also, please see "Embedding PRIME Content into Courses of Both Programs" (Appendix H)

Was Outcome Met?

For outcome #1: ongoing – 3 out of 4 courses have been revised in SOWK; more than out of 4 courses (9 courses total) have been revised in PSYC

Goal #4

Objective 4(3)

Integrate experiential learning exercises into course of both programs

Measure:

(1) Number of revised courses (mid-December 2022 / mid-May 2023)
(2) Interviews with MU faculty (mid-December 2022 / mid-May 2023)

Outcome:

(1) At least 2 revised courses in each program

Data:

- See "Integrating Experiential Learning Exercises into Course of Both Programs" (Appendix I)

Was Outcome Met?

For outcome #1: on the way to being met

- Two courses in SOWK have been revised (SOWK 630, SOWK 631)
- One course in PSYC has been revised (PSYC 682)

APPENDIX A

NEEDS ASSESSMENT OF COMMUNITY PARTNERS

FALL 2022 AND SPRING 2023

GOAL #3 OBJECTIVE 3(A)

FIRST REPORT SUBMITTED TUESDAY JANUARY 31, 2023

UPDATED REPORT SUBMITTED MONDAY JULY 10, 2023

As part of the PRIME grant, Goal #3 Objective 3(a) focuses on conducting a needs assessment across all community partners and clinical internship sites. In the original grant, it was proposed that we conduct this needs assessment four times a year. Beginning with 2022-2023, we propose conducting the needs assessment twice a year. For this second year of the grant, we conducted two sets of interviews – once in the Fall 2022 and once in the Spring 2023 semesters.

We conducted interviews with 10 community partners in Fall 2022 and 13 community partners in Spring 2023. In Spring 2023, three respondents were unable to log on to Zoom, and interviews were conducted through telephone instead. Detailed notes were taken for these three interviews. Otherwise, all other interviews were conducted via Zoom. The interviews were about 30 minutes in length. All 22 respondents interviewed through Zoom granted permission for the interviews to be recorded, and the recordings were transcribed utilizing Otter.ai software. All interviews were conducted during the months of October 2022, March 2023, and April 2023. A list of the respondents for this round of interviews can be seen in Table 1 on the next page.

Respondents were asked a set of three very broad questions: (1) to discuss what they felt interns needed to know in order to succeed in their placements, and ultimately, their careers; (2) to discuss what they felt the programs at MU could do to help bolster their students' success in their placements and careers; and (3) to discuss how they thought the programs at MU could better foster a teams-based approach among current students and interns. In addition, at the beginning of the interviews, to help ease the respondents into the process, community partners were invited to talk about their work and their organizations.

<u>What Interns Need to Succeed at Their Internship Placement and Their Careers</u>

In offering their viewpoints on what interns need in order to succeed at their placement (and ultimately, their careers), respondents focused on two different areas: (a) specific skills and knowledge; and (b) approach and attitude. For the first area, respondents provided detailed suggestions for concrete information and skills, while for the second area, they focused on how interns should approach and contextualize their work experiences. Overall, respondents discussed the second area much more in-depth, suggesting that interns' personalities and mindsets play a larger role in their career trajectory more so than instrumental knowledge and expertise.

Skills and Knowledge

We begin with the first area that respondents opined upon – the instrumental knowledge and expertise that interns will need to learn in order to be successful. These were focused on five areas: (1) a

broad knowledge of diagnosis, interventions, and medications; (2) background in trauma-informed care; (3) cultural competency; (4) understanding the connections between the micro, meso, and macro levels; and (5) understanding the importance of administrative tasks and work. First, a majority of the respondents discussed the need for interns to have an understanding of diagnosis, therapeutic interventions, and medications. The respondents were clear that they were not expecting interns to be walking encyclopedias, but rather, they hoped that interns should have a broad-based understanding and awareness. For instance, one respondent said,

Table 1 List of Community Partners Participating in the 2022-2023 Needs Assessment

Name	Organization
Lakeesha M. Bair-Myers	School District of Lancaster
Patience Buckwalter	Pennsylvania Immigration Resource Center
Erica Collison	Arrow Counseling Services
Breanne Cox	Paragon Behavioral Health Services
Amanda Diehl	Excentia Human Services
Denise Ebelhar	Berks Counseling Center
Julio Fernandez-Mendoza	Penn State Health Sleep Research and Treatment Center
Karen Galbraith	Children's Advocacy Clinic
Meagan Howell-Brogan	Franklin & Marshall Counseling Services
Michael Koblensky	Blueprints for Addiction Recovery
Brenda Long	Penn Medicine Lancaster General Health
Jennifer Lyristis	WellSpan Philhaven
Jessica MacIntire	York City School District
Teri Mahoney	The Academy PA
Janine Malin	WellSpan Philhaven
Hillary Malone	Bethany Children's Home
Yanina Marti-Ramirez	Encanto Wellness Center
Jay Miller	The Ranch Pennsylvania
Karen Mummau	Matters of the Heart Counseling
Jennifer Pelton	Leg Up Farm
Lacenda Plunkert	Pressley Ridge
Samantha Thiry	Franklin & Marshall College DipCares
Janine York	Advanced Counseling and Testing Solutions

The thing I focused on, coming out of school – my whole career really was focused on drug and alcohol (addiction). But I wish that I knew more about, like, Gestalt therapy, and things like that, things that I just didn't get to learn. And then when I went to take a certification test, it talked a lot about things like that, and I was like, I don't know much about this. Then I started looking into it myself. But yeah, maybe just a wider range of different interventions that can be utilized and employed, whether it be drug and alcohol, whether it be mental health or social work in general.

Another respondent said, when I asked what interns needed to know to be successful,

I think having a whole course on medications, diagnoses, how to look at commitments … but the biggest thing is medications, if anything, just kind of being aware of medications. We'll never be able to prescribe medications but being able to – so you're well-versed. That's one thing I had to learn at the behavioral health hospital. I had to learn about diagnoses other than depression and anxiety. I had to learn about, you know, the medications – which ones would come up as an amphetamine and which one would come up as a benzo? You know, not to necessarily think, oh, my goodness, you're using drugs? … It doesn't have to be like – we're not going to medical school. So it doesn't have to be like that but just so you feel more equipped, like writing good clinical notes.

When I asked this second respondent whether they were recommending a more generalist education on medications and diagnoses for interns, they responded, *"absolutely!"*

A third respondent offered, when I asked what skills and knowledge they thought students and interns needed to have in order to be successful,

Just to know, even if – and I think that that can be hard, because in school, obviously, there's limitations in terms of like, time, like we could spend hours and hours teaching students. But I think just having that general foundation, that general understanding of different theories, and some of them, they're going to have a pull towards some more than the others. And I think that can be helpful because just doing some interviews with interns, to some of them, they already kind of have an idea like, "Oh, I like the psychodynamic piece, or I like the CBT piece." And I think that's helpful. Because, as a supervisor, I'm not a psychodynamic therapist, so if that's what they're looking for, I wouldn't be a good fit for them. So I think that's helpful for them to be able – even if they don't have a niche that they're kind of drawn towards yet, that's fine. But I think just having that understanding, but also being able to implement some of those skills within the therapy setting.

To this community partner, it was understandable that students and interns would be inclined towards particular approaches. Even so, she felt that they needed to balance out their own preferences with a broader understanding of the diversity of approaches and theories available.

In conducting the interviews during the Spring 2023 semester, several community partners emphasized not only the importance of being conversant with a broad range of therapies and approaches, but also that clinical abilities and skills are more art than science. A few respondents also cautioned what they saw as an overwhelming preference for cognitive behavioral therapy. As this respondent couched it,

Even with the intern I'm working with, um – you know, a lot of her courses really highlighted cognitive behavioral therapy, you know, which is like, that's – I remember, in my Masters' program, that's what all my professors were teaching. It's the easiest one to teach when it comes to case conceptualization and writing treatment plans. It's because it's very much more "sciency." You know, it's easier to teach science than art. So, when my intern came in, she was very cognitive. But then she needed to have an open mind, which I think it's important. So now, she's learning other techniques, which are more body focused. She's watched some of our clinicians use psychodynamic approaches. She's just learning everything and willing to take it all in. And that's exactly what I think needs to happen.

When I said that I had just conducted another interview with a community partner who shared a similar concern that CBT was being held as the gold standard because it seems so "clean and nice," this respondent said, "*yes – and here's the thing: people need something other than CBT. I agree with her 100%."*

Second, several respondents offered that interns needed to have a better understanding of trauma and a trauma-informed ethic of care. One respondent remarked upon this in general terms, stating that *"the component of trauma focus has to be there; because it doesn't matter if it is a tiny T or a big T – all of us have experienced trauma at some point."* This perception that trauma is a near universal experience, and that interns needed to be well-versed in understanding this, was echoed by other respondents. For instance, one respondent said,

> *From my perspective, and the work we do, it would have to be really, surrounding trauma-based interventions. … You know, that need for generalized trauma training for students, because every type of young person, not everyone, but most young people that you're dealing with, you're dealing with some sort of trauma, right? Whether it's at this level or that level, you're dealing with some type of trauma. It may be a mental health trauma; it could be, you know, an addiction issue; it could all be intertwined right now – you need to have some sort of knowledge of what is trauma. … There's so many labels that are put out there on kids, that I think that trauma, generalized trauma, and you need to know what that means when it could mean so many different things. I think that would be so helpful.*

Interestingly, a third respondent began by talking about the importance of diagnoses and treatments, but then veered into a discussion about the importance of understanding trauma. They said,

> *There's diagnoses and then there's treatments for those diagnoses. But people are complicated. People are complex, right? About losses. That's just one of those universal things that everyone goes through. But there's more than that, right? Like how pervasive trauma is now, we're trying to teach everyone to understand that. There are many different kinds and many levels of trauma experiences through your early childhood experiences, and from the ACEs studies, we know that it reflects on your physical health later in life and everything else that you do. We're all shaped by those. And we all have them to some degree. And the more you have, the more you're shaped. So, I think, in the busyness of learning all these things, we're trying to make sure we get the fundamentals.*

A third major area of instrumental skills and knowledge that respondents pinpointed was that of cultural competency. Several respondents went into some detail about the level and type of cultural competency that they felt interns required in order to be successful. One respondent, for instance, said that *"the cultural piece (is very important) … and that is something that you always have to be willing to learn."* To this respondent, the importance of cultural competency also means that interns should keep an open mind. As they elaborated, *"if you think you know everything, then you pretty much know nothing because every single day, I learned something new … and you need to be humble enough to learn from others. (Sometimes) we have these students who get annoyed, but they need to continue to learn as they move on."* For this respondent, cultural humility is a key aspect of cultural competency.

Two other respondents, in their discussions on the importance of cultural competency and diversity, focused specifically on the aspect of class and socioeconomic differences. For instance, one respondent said that interns need to be culturally sensitive because

> *We do have families who are poor. … You can have all the book skills in the world, but if you don't have those people skills, you're going to suffer. People need to feel that you are genuine, and that you care, that you truly care.*

Similarly, a third respondent who addressed cultural competency focused on how they felt that interns should be encouraged to go out into the community and see for themselves people's lived experiences. They said,

> *Being hands on is important – meeting people where they are, you know in their everyday lives. It may not feel comfortable, but you know, maybe we can send a group of young students out and say to the, you know what, for today, you have $1 to your name, that's all you have. What are you going to do with that $1? How are you going to survive*

from six in the morning till, you know, whatever timeframe it is, but you know, they're going to look at you like, are you crazy? But the bottom line is, for that homeless, young person that's in that alleyway – they don't even have $1. Right. So how are you going to survive? And how are you going to put yourself in their position? You can never put yourself there, so how are you going to even relate? How can you relate? If you go to a teen center, and this kid's, you know, hasn't eaten for three days – how are you going to relate? … Getting some exposure to that is really important … I mean, half the kids who graduate have never even seen a mental health hospital. You know, they've never been to a juvenile center and they have no idea what you're talking about.

For these respondents, it is clear that cultural competency, to them, goes beyond understanding racial and ethnic differences. Part of being culturally competent is also having the ability to have an open mind, and to understand that you can learn from clients. More importantly, for these respondents, they feel that it is important for interns to be exposed to a wide range of experiences, especially to those who are experiencing socioeconomic challenges, as well as institutions where their clients are likely to be housed.

A fourth area of content knowledge and understanding that quite a few community partners pinpointed is the ability to connect the micro, meso, and macro levels, and to understand how larger policy decisions impact work on the ground. For instance, one respondent said that in their opinion,

One of the biggest gaps that (they) have noticed with students for years is like – a macro level understanding of, okay, of like – how federal, state, and local policy interact with the organizations that you work in. I mean, I know students have macro level classes. So I feel like it's – it's kind of like – the theoretical knowledge is there, but like, the conceptual knowledge isn't usually there. So I usually have students, you know, looking at, like – my school district, and then like federal level, you know – like, the homeless students – there's a federal level mandate, and then the state implements that, and then the local school district has to implement that, you know, and so, I feel like the broad picture sometimes is missing, like – decisions that are made up here trickle down and impact what what're doing down here. So, you have to know what's going on, you know?

Another respondent talked about not only their frustration that students seem to be unable to make the connections between the different levels, but that internship opportunities in macro social work tend to be lacking in general.

I spent many, many years working at the Pennsylvania Coalition Against Rape. I was sort of a training coordinator, and all that is extremely macro level work being done at the state and national level. So, there are quite a few of us macro level social workers out there. The trick is that with field work, placements are hard. The placements are hard and I don't know that enough macro social workers are in actual academic departments. By nature, you all want to be in the field collaborating and partnering. So I wonder if that's like – I'm sure somebody must have looked at this, then in departments, the people who are there tend to be more micro.

Finally, several community partners discussed the need for students and interns to understand the importance of administrative tasks and work, and to develop a facility with writing up reports and documenting cases. One respondent said that it was important that it was important for students to learn that *"(t)here's a lot of value to administrative time and tasks … like writing your notes or sitting in a staff meeting*," while another respondent said that interns need to *"learn how to connect their documentation to client treatment plans."* This is, in part, one respondent reflected, due to the fact that *"students need to learn that there is a gap between classroom knowledge and practice on the ground and they need to be prepared to learn to make those connections."* Coursework and curricula often focus on the content and the clinical skills – understandably so. Yet, community partners argue, students need to gain some experience and understanding of the more mundane aspects of service provision, and the value that they can gain. We return to this theme in the next section.

Approach and Attitude

The community partners focused much more on the approaches and attitudes that they felt interns needed to have in order to succeed – all the respondents discussed some element of this. The partners' responses fell into four main categories: (a) to be realistic about success and knowledge; (b) to practice self-care and avoid burnout; (c) to understand the needs of the work and the organization; and (d) to begin a transition to a professional self.

First, all the respondents emphasized that interns need to be realistic about their expectations in working with clients and in their level of knowledge. This is perhaps best summarized by a respondent who said, *"student don't have to be superheroes; people choose what they want to work on and some specialization and interest is good."* This respondent further elaborated

> *I think that sometimes, in programs, that is lost, in the sense that as if you have to be this psychologist or social worker that can treat everything, and it's like, no, maybe actually, you don't have any passion towards that. … For me … I did not want to work with chronic mental health disorders. And it was a conscious decision. I said: I cannot do this. And I'm not a horrible person. I am not less of a psychologist. I just cannot do it. I cannot work in a field where my treatment goal is that you shower today. … And I think that programs need to be kind of like, make students feel okay with that behavioral health is not a unitary field. … You don't have to be able to work in every single field within behavioral health; maybe suicide scares the shit out of you. And you don't want to deal with patient populations that address suicide. And that is completely fine – you want to work with prevention of anxiety and depression in youth, for example, by serving as a liaison with the school system. That's beautiful; that needs to be done, actually. So I think that that is also something important in programs in that sometimes, I get from general Psychology programs is that interns have the feeling of "I should know how to do everything," and no, it's okay. You need to choose actually what you feel most connected with.*

For this respondent, interns need to be realistic about their level of knowledge – they feel that sometimes, interns are trained and socialized to feel that they need to know everything, and that this can be a detriment to their success. A second respondent also emphasized the importance of interns accepting their limited range of knowledge, saying,

> *I think – doing training as a psychotherapist is just so humbling. And you just have to develop so much comfort with like – not knowing, and kind of being patient and present with people. I think so often in life, especially when you're a student, it's like – I should know what to do, like I'm learning things to do, and then I just do them. And this is a situation where it's like – you're not going to know what to do. There's no script, there's no right thing to say or do, or a perfect intervention. You know, so much of this is just being attuned and present and patient with yourself and the other person. So I really feel there's so much challenge in that – like learning how to find some comfort in that gray space, and knowing that there's not a blueprint. That you can't make clients move faster than they're ready to move. So I think that just learning that kind of being – really, meeting people where they're at, and moving at the pace that they're ready to move. So you can't really have an agenda. And that's hard.*

This second respondent, in discussing the importance of interns learning how to be comfortable with not knowing everything, gently also segues into the other aspect of being realistic: that of succeeding in working with clients. Respondents were consistent in emphasizing that interns needed to grapple with the fact that they will not be able to assist everyone. For instance, a respondent had this to say,

> *So, one of the things that – probably the biggest thing that I learned a long time ago when I was an intern from one of my supervisors who had been in the field for 25 years is, with drug and alcohol, you know, you don't see a super high success rate. And I think that with new clinicians, especially interns, they have an expectation that they're going to come in here and they're going to help people. And they're going to see a lot more success than they do. And I find that myself and others, I've noticed, because I've worked with a lot of interns and this comes up a lot of times, is they feel like a little burned out by that they don't see as many successes and their expectations don't get met. And, you know, when I brought it up to that supervisor who had been in the field for 35 years, he said, you have to let go of that, and drug and*

alcohol, and you have to know that your successes are not their successes. These are not your failures either, right? So you're just here as a vessel, you're here as someone who is going to share experiences, and you're going to teach them skills, and then they're going to have to adapt the utilize them. And if they don't, that's not on you. And if they are successful, and they do use, it's also not on you because they're going to take what they have learned and they're either going to apply it or they don't. And when he taught me that in a supervision session, it kind of released me a bit of feeling like I had to really try to get everybody sober. And I was just like, you know what, I'm going to come in here and then do what I know to do well, and I'm going to do it to the best of my ability. And I'm not going to own any of that, because that's their stuff to own and they're going to own their successes, and I'm not going to own that. That was kind of profound for me in the beginning. And so, when I run into interns who also have that experience when they're like – "I just feel like I do all this work, and I'm not seeing a lot of outcomes or success from it" – I always tell them like – you can't with drug and alcohol – it's tough. It's tough work. And now, I don't know what our success rates are. Exactly. It's hard to quantify because you know, you have clients who disengage and disappear, and you don't know – are they doing well? Are they not?

This ability to redefine and re-conceptualize "success" in working with clients, according to many of the respondents, is key if interns are to be successful in their placement and beyond. Respondents were also clear that this understanding might take time to develop, and that interns needed to be patient. A respondent who worked in general behavioral health best illustrated this by saying,

We work with human beings, okay? So the process is not going to be perfect, it's not going to be exact. Oh, there are amazing books out there that talk about how it's supposed to be. But because we're working with human beings, it doesn't work like that; it's not linear. It's all over the place. And it gets better as you continue practicing. And I see the interns even looking at you like – you don't know what you're talking about, right? Like, maybe, who gave you your license, right? But then, in the future, they start becoming more mature as they keep learning that it's not black and white. Every client has their own history, and every client deserves the same amount of time. You're not going to have – you're not necessarily going to have a fix for that client and you might just have to sit down and listen and just be present. And sometimes interns come with this "I have to fix this." It's like they're a superhero and they come with this superhero idea of who we're supposed to be as a mental health therapist. And then slowly, hopefully, they realize that it's not as simple as that. It's not only that the client didn't do the homework. Maybe we have to give them more tools or maybe they didn't have someone believing in them. So you keep learning.

One of the community partners connected this to respecting the autonomy of clients. To her, if students were to succeed in service provision in behavioral health, they need to rethink their relationship to their clients and to meet clients where they are. She elaborated,

You know – the individual choices, and I say that to my team all the time: Guys, they are adults. You know, like conflicts of their smoking is killing them. We know it's killing them. But yet, they asked us to take them to the store and they're buying cigarettes. They are adults and they have choices in their recovery. So I think understanding behavioral health, especially understanding good recovery principles is important.

As interns learn to develop realistic expectations about their level of knowledge and their "successes" with clients, commensurately, they need to learn how to practice self-care and avoid burnout. All the respondents discussed the importance of this approach and attitude to varying extents. When asked what they thought interns needed to know to be successful, one respondent said,

You know, I mean, definitely, the self-care part is important. … you want your students to be realistic about it, because you know, they not only have school classes and schoolwork – they go to class, they have their regular part of their job, and they have their intern part of their job, which is a big load, plus their personal life, you know? I want them to enjoy their family too. So, every week, we talk about that. It is great to see that enthusiasm, and you don't want to squash that. But you people to not feel like they have to go overboard, you know, or have to find all the answers.

Respondents repeatedly emphasized that ultimately, this is a marathon, and that students and interns need to learn to pace themselves. Otherwise, they would not be able to sustain themselves in the behavioral health care field for long. Not only do newcomers to the field need to learn not to go overboard, they also, many respondents said, need to find other diversions and meaning outside of the work, as can be seen in this community partner's response,

> *They need to take care of themselves more than they need to take care of their jobs. I hate to say it like that, but the amount of effort we're putting into our jobs – you need to put more effort into yourself and you need to diversity your support system. So I've been doing this for almost 20 years now. I'm still here and kicking because I have a wonderful support system. And I have found philosophy. So when you bring all these things together, I'm ready. I don't feel burned out and I don't feel tired. I don't feel any of those things – knock on wood. So you must work on yourself more than you work on the patients or whatever job you're at. I think they definitely need to find some sort of purpose outside of work. Yes, you may be the best physician, social work, counselor, sociologist, anthropologist – you may be the best. But eventually, that will go away. Because eventually, we retire, right? Even the people – you know, we have people here who love this job, and they told me, I'm going to die at my desk. No, you're not, you're not going to do that, you know? No. So you need to definitely find a purpose more than your profession.*

Interestingly, while all respondents emphasized the importance of self-care and preventing burnout, not many of them came up with specific ideas of how to put in place early preventive education and training. Many seemed resigned to the possibility that only once someone is working in the field will they begin to comprehend the importance of self-care. For instance, one respondent reflected on her own education and experience,

> *I've talked a lot about that with my intern, and we focus on the self-care. And I said, I'll be very honest. I know what I learned in school; we talked about it. I ignored it. And I was like – this is great! I'm fine. I can compartmentalize. I can squash those feelings. It'll be cool. And then, it eventually does hit you. And it usually makes up for lost time. So yes, I told her and I said, you know, I was one of those people who said, "I do this for a job. I don't need a therapist. I'm fine." And I said to my intern – don't be afraid because therapists still need therapists; you still need to work on that. And I think just the stigma – even though we're in social work – there's still a stigma within social work to have. We are therapists. We're in social work. We can be therapists to ourselves. And that's definitely a misconception. I'm being very real with the interns, especially if they are coming into a high turnover place – or just behavioral health or working with disabilities will hit really hard on the self-care piece. No – you do need it. I wish they kind of forced us to take self-care. Like – I honestly wish that they really did force us, because then it could help change your mentality once you get over the initial barrier or the hurdle to get into it. So I've really talked with my intern about not being afraid to ask for help, because you're going to see a lot of really – the good, the bad, the ugly – and sometimes, the ugly is very hard to forget.*

As discussed later on, respondents strongly encouraged that coursework and curricula incorporate discussions of the importance of self-care, and also teach students concrete strategies. Yet, this respondent stated that while she was lucky enough to have this as part of her coursework, she did not take it seriously, telling herself that she would be able to handle everything.

These first two themes identified by the respondents focus on the individual – the intern themselves, and how they need to be able to focus on their own cognitive, emotional, and mental well-being. The next two themes focus on instrumental expertise. While the emphasis is still on the individual and their self-perception and development, the focus here is on developing an appropriate attitude and approach towards work and the workplace.

First, all the respondents talked about the importance of interns learning about the workplace and the organization of health care. Everyone made at least a brief mention of the importance of learning about how health insurance works, and the importance of keeping good documentation. While respondents do

concede that interns will be trained and taught this information over time, many of them continued to emphasize that interns need to understand and learn, at an early stage, that their work is situated within a larger health care system that they need to navigate. In other words, interns need to understand and accept, early on, that it is unavoidable that they will need to do "grunt work" alongside working with clients. One respondent, for instance, spoke about how in their work, they constantly fought with insurance companies to keep their clients in treatment, and that interns needed to learn how to document deficit-based needs for that reason (even if they are taught to work with clients on a strengths-based paradigm). Another respondent stated that even more than learning the nuts and bolts of health care systems and organizations, interns need to learn about and be comfortable with the evolution of these systems, saying,

> *Definitely, flexibility and adaptability are some major key qualities to have. I mean, if you're expecting things to be the same, every day, right? … Healthcare is just changing faster than I've ever experienced in all my years. And so organizations need to be flexible and adapt, which means then, that trickles down to the individual employee, right, like that, all of a sudden, well, hey, we're going to reorganize, or we're going to do this instead. And we're streamlining this, like, just be ready for it and don't take it personally that your department or wherever you were was doing something wrong. It's just there's so many demands and different things that are changing – you can't stay the same, you just have to keep going. That adaptability and flexibility is so key.*

Finally, a few respondents talked about the importance of interns beginning to learn to transition from a student to a professional mindset. For these respondents, the internship placement is an ideal opportunity for interns to begin moving away from "student life" to "professional life." Key to this shift is understanding that you are now within a different context, and that different obligations and responsibilities now weigh on you. I quote this one respondent at length, who shared in-depth their insights into how interns need to learn how to shift to a professional context.

> *My semesters with the interns seem like they're getting shorter and shorter, and now, they have a fall break. You know, they're done like, the first week of December, which is not when we're done, and they don't let them work over the winter breaks. To me, they need to be allowed to count hours over the breaks and work if they want to because that all has to do with a continuity of care. And if we're talking about continuity of care, we're expecting and training professionals in the field. So, no, we don't just take off four to six weeks. You don't do that in the real world. And your job – you're lucky to get two weeks off in a row. … I get that everyone needs a break, and they absolutely should have a break from school as well, but in my mind, you get a break for a week at Thanksgiving, you come back, you get a two week break at Christmas, like that should be adequate because you're not gonna have to take classes. … Now, I don't know what the true expectations are when they're in a field placement because I've had too many students come through where I've felt like I've had conversations with that maybe I shouldn't have, like, granted, there's a chain of command. And I know you may have gotten an email and this is what you thought, but as your field instructor, you should be coming to me before you respond to an email from the district, and now the superintendent's involved. Like, you're having a whole conversation with the superintendent about wanting to go virtual, but you didn't have a conversation with me first. Because they didn't think that it was my decision? Well, it is my decision, because if I can't give you 17 hours of virtual work a week, some jobs are just not virtual. … In any organization, there's a chain of command, and there's expectations of what you're to do, and you need to follow that. So, I think just even basic things like that, I think some of the students who are still too much in a student mode, so attendance is questionable as well. And then, you know, they want to take time off – I feel there's been no clear communication as far as that. But then, I'm asked how to help you make up hours. If I don't go to work, I don't get paid unless I have hours, PTO, or whatever. So if you take off time, because you want to go away on an extended trip, how is that my problem? How am I going to find extra hours for you?*

Some of the concerns this respondent raised arise from structural and organizational mismatches – e.g., the university's academic calendar does not sync well with other workplace timelines. However, this respondent does focus on specific issues that interns might not have been exposed to in a classroom setting –

specifically, meeting the requirements for in-person work (with much less individual flexibility) and understanding how to interact within a chain of command.

How MU Programs Can Better Prepare Interns for their Placement and Careers

It should be said that overwhelmingly, the respondents felt very positively towards their interns and their experience working with MU interns. They did have several recommendations for how MU can better prepare the students, but it does not take away from their overall positive assessments. Not surprisingly, respondents focused on the curriculum and education aspects in answering this question. However, three respondents discussed non-curricular/education aspects of how MU can better prepare students, and I discuss them first.

The three respondents focused on different issues. First, following from the last example in the previous section, one respondent stated that they would like MU to better clarify how time worked can/should be counted as field hours in terms of program requirements. In addition, this respondent also recommended that MU map out more clearly for students a protocol for reporting and interacting with internship and faculty supervisors as well. Second, another respondent also stated that it would be helpful for MU to provide an overview to the students of the entire process toward licensure, and that MU should do this early on in the student's time in the program. This respondent said,

> *One more thing. The interns said they don't get prepared – they don't know what are the next steps for licensing, and they said, yeah, the university didn't mention this. Now, I don't know if it's true or not, but it keeps coming up. So one way to prepare them better will be to tell them: if you decide to go the route of mental health, here are the steps. … They're going to be more prepared. If they know ahead of time, then it's more clear that yeah, this is the path I want to take. I know I have to invest in this.*

A third respondent focused on the university's role in continuing education and training, saying how much they appreciated the university's focus on providing accessible and affordable training and continuing education. In order to help retain behavioral health care practitioners, this respondent argued, they need to be able to continue to access affordable continuing education training, and they say MU as playing a vital role in this aspect of professional retention.

The other respondents, when asked this question, focused on issues of curriculum and education, primarily focusing on specific topics and issues that they felt the faculty at MU should incorporate. Many of these suggestions aligned with their responses to the first question on what they felt interns needed to know in order to succeed in their placement and careers. For instance, several respondents who focused on the importance of self-care and preventing burnout also talked about the importance of including this in the curriculum, and provided specific recommendations. For instance, one respondent said,

> *Some sort of mindfulness, and some sort of mindfulness, deep breathing, and meditation, right? Some sort of ability where the intern is able to regulate themselves. Also some sort of course which would involve some sort of journaling, right? Because your personal values will be tested. They will be – I hate to say – exposed, and you can't let your personal values and morals get in front of clients, because that'll just lead you to burn out even faster. So do some sort of journaling, just writing down your thoughts and just being able to accept those thoughts, whatever they are. I asked one of my Millersville interns, "Hey, write down in your journal your top five personal values." And you don't need to tell me but you've got to journal on them because the more you're aware of them, the less of a response you'll have to give, right? You won't start crying in group or you won't get angry in group, right? You know? Because, yeah, okay, this person feels this way in group and I feel differently. Okay. We're just going to let that slide off. The more regulated our interns are, then the easier time they're going to have wherever they go.*

A second respondent, who felt that understanding self-care and preventing burnout was important, opined that classes needed to incorporate this, even when the course topic is focused on other issues. For instance, in a course on "Psychotherapy," while students were learning the techniques and best practices, this respondent felt that it was important for the course to also incorporate self-care and preventing burnout as practitioners.

Just as several respondents felt that the students needed to have an understanding of trauma-informed care, they also recommended that the students receive more training and curricular work on a trauma-informed framework. One respondent felt that education and training on the trauma-informed framework should go beyond the micro level, saying:

> *You know, some of the materials and things that are out there on trauma informed care, there's also trauma informed care organizations, and the close those organizations are to adhering to the principles of that as an organization, the better off usually, of everybody involved, like not just the people they serve, but also the people who work there.*

In addition to self-care/burnout and trauma-informed care, respondents provided a hodge podge of other suggestions about issues and topics that should be included helping better prepare interns for their placements and careers. Some of these suggestions are more academic. For instance, one respondent emphasized the need for interns to be able to evaluate evidence-based versus non-evidence based treatments. A second respondent suggested a class on adolescent development, while a third recommended a course on medications, diagnoses, and the side effects of medication, as well as training on how to take and write good clinical notes. Other suggestions focused on more applied knowledge. One respondent proposed a course where students were taught about the roles and expertise of the different health care providers in the behavioral health care field, while another suggested that students acquire more background and knowledge on the business side of behavioral health care, e.g., knowing how to fill in and file waiver forms and being familiar with required documentation for Medicare and Medicaid. Yet a third branch of recommendations focused on experiential knowledge. One respondent emphasized the importance of having the students come out into the community so that they can meet people where they live. They said

> *Getting some exposure to that, you know, is going to be really important because that is a hard road. Getting some exposure and everyone loves to volunteer, right? People love volunteers, so I think that having students do more out in the world, in the community centers and out into the field – that is really important. I mean, half the people or half the kids who graduate have never even seen a mental health hospital. You know, they've never been to a juvenile center, you know, they've never been in a detention center, and they have no idea what you're talking about.*

Finally, several respondents emphasized the importance of teaching students sound and effective communication skills – in interacting with supervisors, peers, and clients. For instance, one respondent, when asked how MU could better prepare students for internships, said

> *Well, students need to have more confidence in themselves. They need to be more pro-active in asking for help. And really, they need to learn to communicate more and with more clarity. In-person training and experiences need to be the priority, because you can only do so much virtually. So much of this communication has to do with rapport building, and students need to have in-person training so that they learn how to build relationships.*

Several respondents similarly emphasized the importance of good communication skills, focusing on clarity, active listening, and building relationships.

Specifically, three community partners interviewed in Spring 2023 discussed the importance of students learning to develop good telephone skills (this was offered by respondents in three back-to-back-to-back interviews). For instance, one respondent said

I've noticed interns come in, and they're really really terrified about making telephone calls. I think that's a generational thing. I think it is, and it's fascinating to me, because we have to make a lot of telephone calls. I mean, we do a lot of emailing too. But just even some of these very simple – seemingly simple – skills, you know, recognizing that because of changes in technology and things like that. But a lot of younger folks, you know, they just don't have as much experience with picking up the phone. Why? When you can text the client and sometimes that's the best way to communicate – absolutely! But sometimes it's not. And so, you know, especially in our setting, I mean, we're interaction with kids, teens, grandparents, parents – it's a population that can be very difficult to get consistent communication with because their lives are complicated. So you know, figuring out being comfortable communicating in different ways is important.

A second respondent said, in discussing the importance of communication skills for interns,

I'm happy people can write a good email. I like email to an extent because it's quicker, it's easier. There's a paper trail, like you know, when you last reached out to them. But I do see that with my grad student though – I think she was better at it because did a lot of fundraising for her soccer team, so she had to make those cold calls. But my undergrad students last spring – when I said about calling, like – they had panic attacks. And they were like – I don't know what to do. They were so uncomfortable that I said, you know what, I'll make the calls. You just listen to how I make the calls, take notes – I'll do it, you just learn from me. And so that's kind of how we modified but I think because COVID is going away, more and more places are opening. And so, I think now, we're have to make phone calls more.

For many of the community partners, it was important the coursework and curricula focused specifically on strong communication and active listening skills. For three respondents specifically, it was important for the students and interns to learn how to use what might be considered "older" technology in interacting with their clients.

It is important to emphasize once again that the respondents were, overall, very positive about their interns and their partnership with MU thus far. Their suggestions were offered in a spirit of wanting to improve the internship experience and learning for the students, and admittedly, to make supervision a bit easier for them. It is also interesting to note that some of the community partners remain unclear about what MU already does or doesn't do in terms of intern preparation and also curricular content.

<u>How MU Programs Can Better Foster a Teams-Based Approach Among Students and Interns</u>

The last major question I posed to the community partners was the one that they had most difficulty answering. All the respondents agreed that it is important for interns to learn how to work well in an interdisciplinary team, and several of the respondents talked convincingly about how well interdisciplinary health care teams work in their own workplaces. However, when I prodded respondents to suggest how we might be able to help inculcate a teams-based approach among students and interns, many of them drew a blank. Several of the respondents provided broad responses, with one saying that we need to teach students that it's okay to be part of a team and that's it okay to push back on the cultural expectation to do things on your own. Some respondents recommended inviting speakers from various backgrounds to give presentations and talks to the students.

Several respondents talked about the importance of getting students out in the field and giving them opportunities to participate in role play and simulations. Some respondents provided very specific ideas on how these activities could be implemented. For instance, one respondent said

I'm going to tell you – it was never done with me. During all my years of training, I never had a situation where they would put us in a situation where we would do role playing. Like, you're the social worker, you're the person working with the patient and getting them housing, you're the psychiatrist, you're the psychologist, you're the nurse. You need to force yourself to play the role of "what if I'm a biological psychiatrist, right?" Okay, I want you to play that role.

Instead of fighting with everyone, I want you to collaborate. I think that exercise was never done with me. I think that it would be super important, forcing students to basically adopt the role that they will never even have, to understand what it is to face something else.

A second respondent suggested,

I think what can be done is even something like a senior project, and maybe connect students so that they have to work together. So, have a student of a particular discipline partner with a student from another discipline and work on a senior project together. That can show how both agencies, and perspectives of both agencies, some into play, and how they could complement each other possibly. I think what might also be good too, is if I pick up a student and someone else in another discipline picks up another student. And what we do may be a little different. But we know those students are going to be working on that project together, because they were assigned at the beginning of the year, and they it from the beginning. Then, maybe we swap and that other student be able to shadow with the other agency, even if it's only a couple of days. … Because you can hear it from someone else, but if you haven't really experienced it from that lens, you're not really to know.

Yet a third respondent suggested something more akin to a medical residency rotation system, saying

Maybe they could form groups. Like they could have a cohort of five or six within a two year span, or one year span. They could meet and they're going to do a day of shadowing with mental health care providers and then they're going to sit and debrief with their group. They're going to have different leaders within that group. Maybe they might have a psychiatrist join in, then a social worker. Your cohort is going to get together on a monthly basis and it could even be counted towards your internship hours, I think. Just take an hour, and say you're going to have a rotation like – in the psych hospital, you're going to rotate at an outpatient facility at a partial hospitalization program, at a pharmacy even, imagine! Yeah, like one station for a day or two. Or maybe, internships could be rotated – one semester at behavioral health, one semester at a pharmacy, and one semester at a partial hospitalization program.

While some of these suggestions were very detailed, respondents were also aware that logistically, these might be difficult to organize and implement. I note that while respondents were thoughtful and enthusiastic in their recommendations, they understood that there might be logistical challenges in implementation. Rather, respondents were offering these suggestions as their ideal of how fostering a teams-based approach might best be carried out.

Two respondents had an interesting approach to inculcating a team-based approach among students and interns – reframing how adopting such an approach would be of immense value to themselves. For instance, one respondent said,

You know, I would hope that interns would be able to see how the team dynamic helps them by sharing all of the responsibility. One of the bonuses of a team-based approach is to prevent burnout for yourself.

A second respondent had a similar approach to reframing, saying,

I feel like when we get into that hero complex, what we see is that then, we have major boundary issues that come up. And then we start this unilateral decision making: I'm the only one what knows what's right for this client. So I usually like to use that frame of reference – when we have conversations about boundaries and stuff like that – you know, you are not the end-all and be-all in this child's life. You will put yourself in a position where you're going to end up basically having professional ethical dilemmas. We have to approach it as a team. You have to rely on your colleagues to maintain that healthy boundary, and to ensure that you know, you aren't, positioning yourself as some sort of hero. I guess that's sort of how I would frame it.

Conclusion

Overall, community partners provided positive assessments of their interns and of their partnership with MU. However, they did feel that interns needed to have some more specific knowledge and skill sets in order to better prepare them for their placements and future careers. It is my assessment that some of these skills cannot be reasonably taught until an individual has accumulated some experience in the workplace – for instance, knowledge of and facility with Medicare and Medicaid forms. Some of the respondents' suggestions, in particular, those for fostering a teams-based approach, can also be logistically challenging and might not be feasible.

My main recommendation is to provide the community partners with a somewhat detailed description and explanation of what the students are learning, and how the program is working to incorporate these suggestions. As mentioned earlier, several respondents did not have clarity on what MU already does or doesn't do, and this communication might be helpful in putting everyone on the same page. It is quite likely that both the Social Work and Psychology programs already do this, and if so, I would recommend continuing and/or refining this practice.

APPENDIX B
GOAL #3 OBJECTIVE 3(B)
FALL 2022 IPE Webinar Evaluation

Sample Size

For the IPE webinar training, 56 respondents only filled out the pre-test survey, 26 respondents only filled out the post-test survey, and 92 respondents completed both pre- and post-test surveys. A few respondents completed the same survey twice. For these individuals, we included the first survey they completed, and discarded the second.

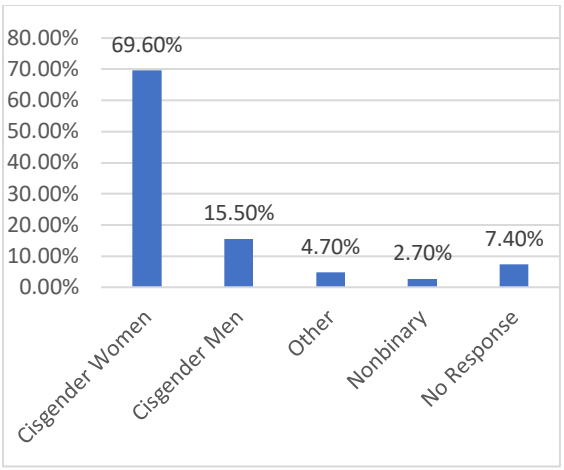
Demographics (Based on the Pre-Test Survey)

As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, and which program, if any, they were affiliated with at Millersville University. Lastly, they were also asked how many years they had worked in behavioral health. **Overall, a majority of the pre-survey participants identified as cisgender women, white, not of Hispanic, Latino/a or Spanish ancestry, and straight. A slight majority of the participants identified as students, and slightly less than a majority identified an affiliation with the Social Work program. Finally, participants stated a mean 11.39 years of experience in a social work-related or behavioral healthcare field.**

The pre-test sample included 103 (69.6%) respondents who identified as cisgender women, 23 (15.5%) who identified as cisgender men, seven (4.7%) as other, and four (2.7%) as nonbinary. 11 (7.4%) respondents did not provide a response for this demographic variable (see Figure 1).

Figure 1

Participants' self-identified gender (n = 148)



115 (77.7%) webinar participants self-identified as White, 11 (7.4%) self-identified as African American, eight (5.4%) self-identified as bi- or multicultural, three (2.0%) identified as Asian, and three (2.0%) identified as other. Eight (5.4%) respondents did not provide a response for this demographic variable (see Figure 2). 126 (85.1%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 16 (10.8%) participants said they did. Six (4.1%) participants did not provide a response to this demographic variable (see Figure 3).

Figure 2

Participants' self-identified race (n = 148)

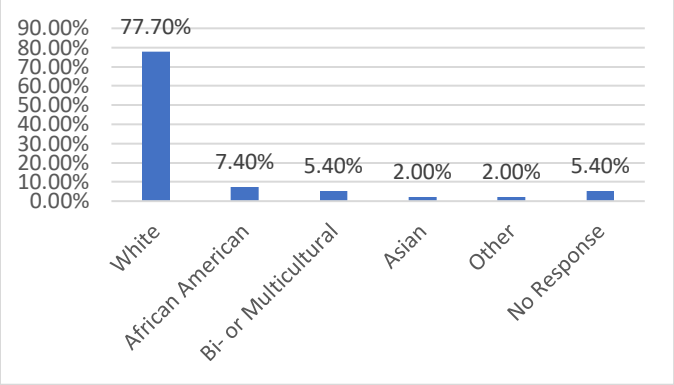
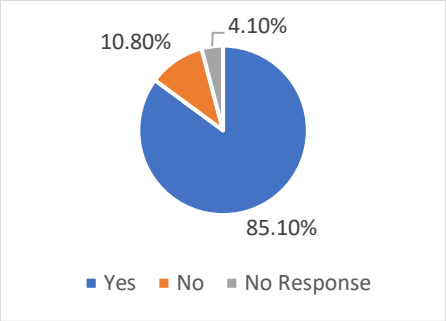


Figure 3

Participants' identification of Hispanic, Latino/a, or Spanish ancestry (n = 148)



Participants also answered questions about their self-identified sexual orientation. Here, 113 (76.4%) respondents self-identified as straight, 11 (7.4%) as bisexual, six (4.1%) as gay, 5 (3.4%) as queer, 3 (2.0%) as lesbian, and 3 (2.0%) as pansexual. Seven (4.7%) participants declined to provide a response for this demographic variable (see Figure 4 on the next page).

In addition to demographic questions, participants answered questions related to their status and program affiliation (if any) at Millersville University. 74 (50.3%) of the participants said they are students, 59 (39.9%) identified themselves as community providers, 10 (6.8%) identified themselves as faculty, and 4 (2.7%) identified as staff. All respondents provided a response for this demographic variable (see Figure 5 on the next page).

Figure 4

Participants' self-identified sexual orientation (n = 148)

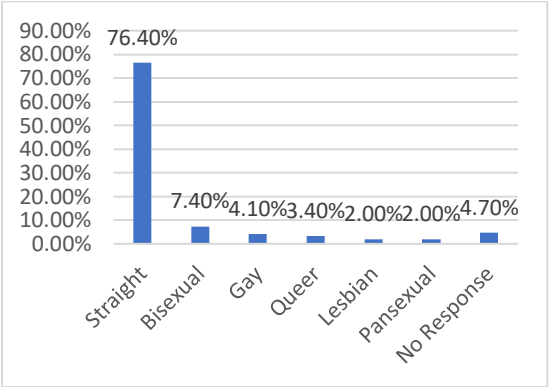
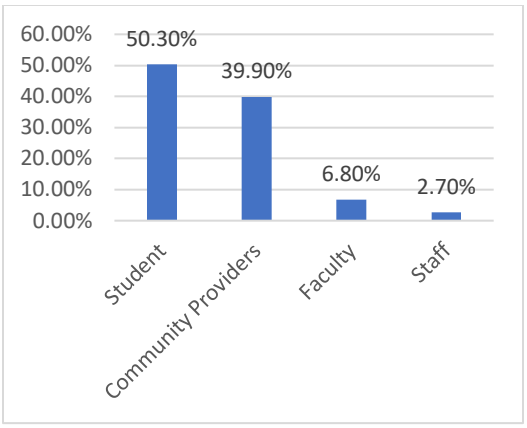


Figure 5

Participant status (community provider, staff, faculty, student) (n = 148)

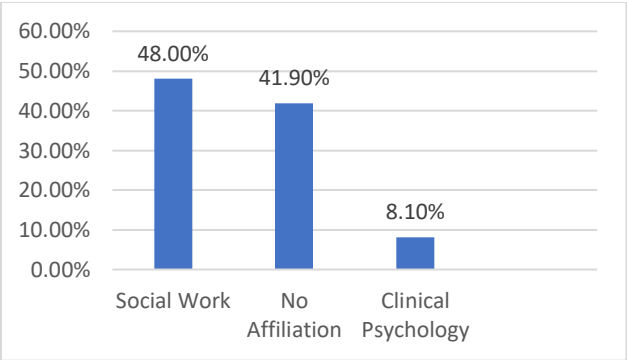


62 (41.9%) did not identify a MU program affiliation, while 3 (2.0%) did not provide a response to this question. 71 (48.0%) participants said they were affiliated with the Social Work department, while 12 (8.1%) stated that they were affiliated with the Clinical Psychology program (see Figure 6 on the next page).

Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 139 (93.9%) participants provided a response while 9 (6.1%) did not do so. Responses ranged from zero to 40 years in the field and the mean was 11.39 years (*SD* = 10.61). The median years worked was 8.

Figure 6

Program participant is enrolled in at MU (n = 148)



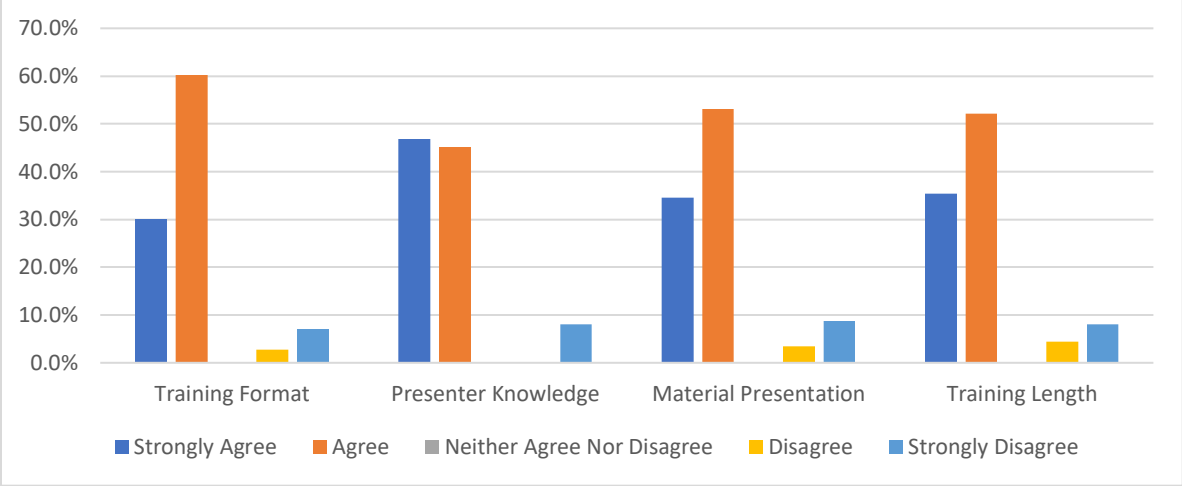
Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included on the post-test survey. Participants were asked to respond to each statement by selecting *strongly disagree*, *disagree*, *agree*, or *strongly agree*. Responses were provided for 113 out of 147 surveys for these four

items, resulting in a response rate of 64.9%. Overall, participants were positive about the training. 102 (90.3%) participants strongly agreed or agreed that the format for the training met their needs, while 104 (92.0%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 99 (87.6%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 99 (87.6%) participants strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7).

Figure 7

Participants' Perceptions of Presenter and Training (n = 113)



Knowledge, Skills, and Attitudes About Interprofessional Collaborative Practice (IPE) – Quantitative Data Analysis

In addition to questions about demographics and the training, participants were asked, in both the pre- and post-surveys, to select the best response to four statements regarding their knowledge, skills, and attitudes, about IPE. Using a Likert scale, participants could select *strongly agree* (coded as 1), *agree* (2), *neither agree nor disagree* (3), *disagree* (4) or *strongly disagree* (5). Participants were asked to respond to four statements:

(1) I am confident in my current knowledge about interprofessional collaborative practice competencies.
(2) I am confident in my current skill level in applying interprofessional collaborative practice competencies.
(3) I believe that interprofessional collaborative practice is an important component of practice delivery.
(4) I believe that interprofessional collaborative practice can provide positive benefits in the delivery of practice.

Descriptive Statistics

In the pre-survey, we received 148 responses for items #1, #2, and #3, and 146 responses for item #4. Respondents generally rated their knowledge, skills, and attitudes about IPE towards the "strongly agree" and "agree" end of the scale. Means were 2.39 for items #1 and #2, 1.54 for item #3, and 1.49 for item #4 (medians were 2 for items #1 and #2, and 1 for items #3 and #4). Responses leaned towards the "positive" end of the scale, as can be seen in Figure 8 on the next page.

In the post-survey, we received 117 responses for items #1 and #4, and 116 responses for items #2 and #3. In general, respondents still rated their knowledge, skills, and attitudes about IPE towards the "strongly agree" and "agree" end of the scale, but we see a shift towards the more positive end. Means were 1.63 for item #1, 1.68 for item #2, 1.24 for item #3, and 1.25 for item #4 (medians were 2 for items #1 and #2, and 1 for items #3 and #4) (see Figure 9 on the next page).

Inferential Statistics

For this webinar, we matched 92 respondents who completed both the pre- and post-webinar surveys. A two-tailed, t-test for dependent samples was run for each pair of statements for these 92 respondents to determine if their mean changes in responses were statistically significant. Overall, we see statistically significant changes for all items in a "positive" direction (moving towards the "strongly agree" end of the scale) (see Table 1 two pages after). The magnitudes of the webinar's effects were also large, as Cohen's d was 1.025, 0.930, 0.867, and 0.785 for items #1, 2, 3, and 4 respectively (following a guideline of 0.8 as indicating a large effect).

Post-Webinar Qualitative Data Analysis

In the post-survey, we posed two open-ended questions to webinar participants: (1) Which aspects of the training were most beneficial to you? and (2) What do you plan on immediately implementing as a result of attending the training? Below, we provide a summary of participants' feedback and responses. 106 participants provided responses to the first question, while 83 participants provided responses to the second question.

Figure 8

Participants' Perceptions of Their Own Knowledge, Skills, and Attitudes About Interprofessional Collaborative Practice (IPE) (Pre-Webinar)

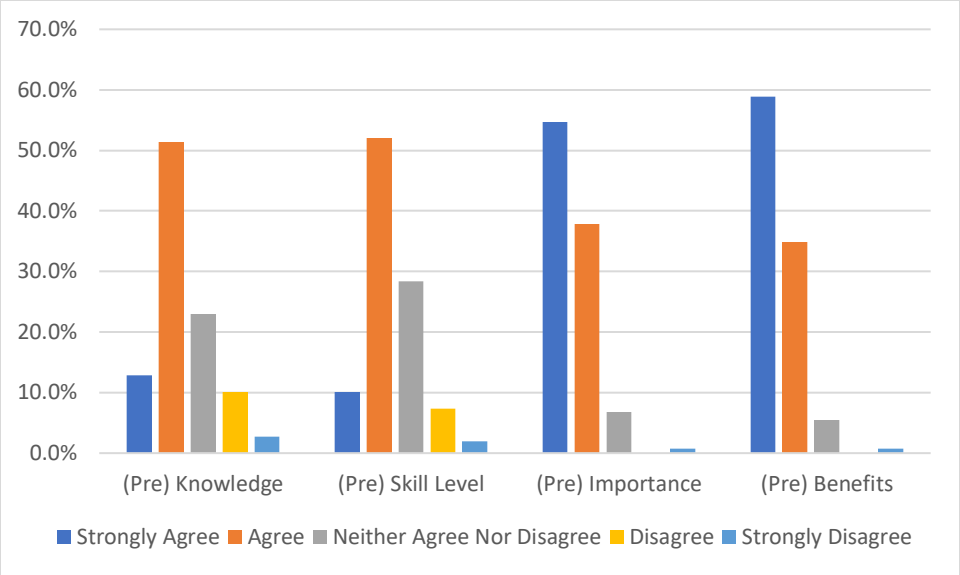


Figure 9

Participants' Perceptions of Their Own Knowledge, Skills, and Attitudes About Interprofessional Collaborative Practice (IPE) (Post-Webinar)

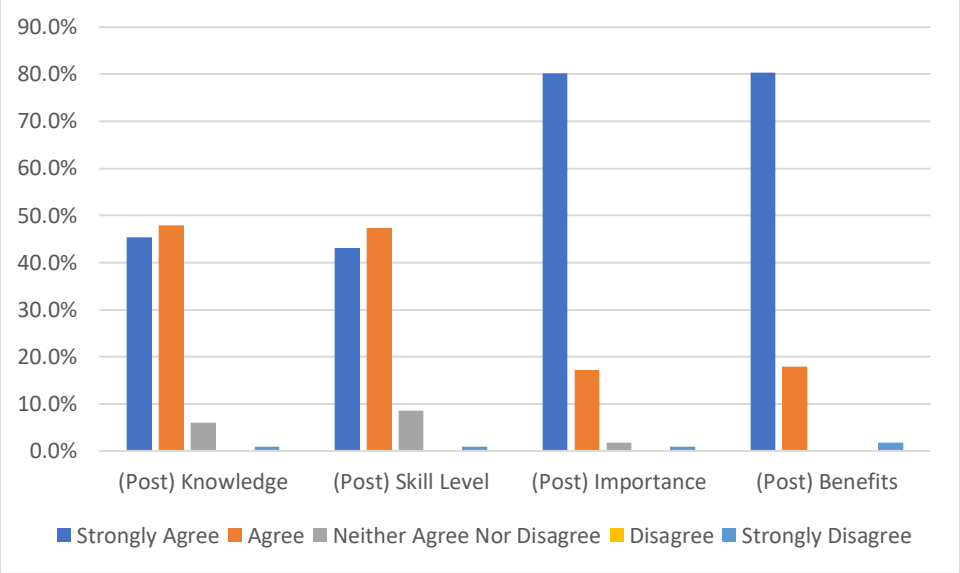


Table 1 **Dependent Samples T-Test Results for Fall 2022 IPE Webinar (n=92)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about interprofessional	2.37	1.66	< 0.001

collaborative practice competencies.			
I am confident in my current skill level in applying interprofessional collaborative practice competencies.	2.36	1.72	< 0.001
I believe that interprofessional collaborative practice is an important component of practice delivery.	1.60	1.30	0.001
I believe that interprofessional collaborative practice can provide positive benefits in the delivery of practice.	1.57	1.27	< 0.001

Most Beneficial Aspects of the Training

Participants' responses for this question fell into two broad categories: (1) the format of the webinar; and (2) the content of the webinar. Overall, participants' responses were overwhelmingly positive, with several participants indicating that they found the webinar to be of tremendous benefit overall. For instance, one participant responded *"the entire meeting"* when asked which aspects of the training were most beneficial, while another participant said *"I loved the reinforcement of the value and importance of soft skills."* A third participant responded they found the entire training to be helpful, and that the speaker's *"discussion and examples were all super helpful, as were the breakout discussions."* The majority of the comments were also very general, focusing more on broad themes and areas.

As hinted at by the third speaker's response, there were two aspects of the webinar's format that participants singled out as being beneficial. First, many (25; 23.6%) participants said that that they found the breakout rooms and small group discussions to be beneficial. One participant stated that they *"enjoyed the discussions in the breakout rooms,"* and that it *"was good to hear the experiences and lenses of social workers who have more experience."* Another participant said that they found the *"the breakout rooms where (they) could discuss and collaborate as a small group"* to be most beneficial, while other participant said that they felt the *"(s)mall group discussions are always a benefit to gleen (sic) knowledge from others in the field."*

Second, many (27; 25.5%) participants found the personal and lived experience examples presented to be most beneficial. In particular, participants appreciated hearing from behavioral health care providers who have had extensive experience in IPE. For instance, one participant stated that *"(l)istening to the experiences of social workers currently full time in practice"* was most beneficial, while

similarly, a second participant said that it was most beneficial *"(h)earing input from those currently in practice."* A third respondent said that it was *"super helpful to hear from professionals that had more experience than (they did)."*

As for the content of the webinar, participants identified three key themes to be of major benefit: (1) role communication and clarification; (2) competencies; and (3) safety. First, several (15; 14.2%) participants discussed the benefit of learning about how to best be part of IPE, especially with understanding the roles that professionals of different backgrounds bring to the table. Two participants said it was helpful to learn about the *"theory of profession centrism,"* while a third respondent said it was beneficial *"learning how to deal with other team members who might have a different approach or view."* Webinar participants also seemed to understand from the training that different disciplinary backgrounds bring different benefits, and that it is important to learn about how each team member can best contribute. For instance, one participant said that they found it helpful to discuss *"what roles different professions can take and how they can do it without being in a hierarchy."*

Some participants also mentioned how much they appreciated learning how social workers can articulate their value in an interprofessional team setting, with one saying, *"I enjoyed the direct examples of how social workers can advocate for themselves and their importance on a team,"* and another saying it was beneficial for them to hear *"view points (sic) of social work professions dealing with their profession not being respected."* In contrast, a clinical psychology student discussed how the training taught them to appreciate social workers, saying

> *This training was beneficial for allowing me to realize the importance of everyone's roles in treating an individual. Specifically, as a clinical psychology student, we are familiar with needing to work as a team with PCPs, psychiatrists, and families, but it is also important to understand the roles that social workers or other mental health professionals play in a team.*

The other two content areas were lightly touched upon by a few participants. Two participants felt that learning about competencies was beneficial, with one participant saying

> *I really appreciated learning about the IPEC Collaborative Competencies (2016). I had never heard of them before, so being able to learn about them was very beneficial to me. I also appreciate how the new updates were included in the presentation. The Quadruple Aim was also interesting to learn about.*

Finally, six participants focused on the benefit of learning about the importance of psychological safety in IPE, with one participant saying that they appreciated the *"reminder that change can't happen without psychological safety, and to create that culture."* Another participant said that the focus on psychological safety *"resonated with (their) beliefs and (they) think this is a crucial aspect in really any type of social work – whether collaboration between agencies or developing rapport with (their) clients."* Yet a third participant said they *"appreciated the brief discussion of safety and power dynamics,"* but felt that the webinar could have expanded on this discussion.

Implementation

The participants' responses on what they plan to immediately implement as a result of the telehealth training were quite homogenous, and flowed directly from what they found most beneficial. A majority of participants stated that they would implement the role clarification and

communication information they learned from the webinar, while a smaller number focused on psychological safety and education.

Three (2.8%) participants said they would immediately implement what they have learned about psychological safety in IPE, with one saying they plan to *"increase psychological safety of others,"* while another said they plan to *"learn more about what psychological safety is/how to implement."* A third participant provided more detail, saying

> *Aspects of a safe culture – in my old position, schools somewhat pushed my agencies input (sic) to the side or didn't want to consider it during meetings. Now that I am in a leadership position role in a school, I want to make sure the environment/culture is open where people can freely share ideas and express concerns (especially in a meeting setting).*

Seven (6.6%) participants focused on how they would continue to share the information they have learned about IPE in further education. Those in teaching roles saying they would impart this information to their students (e.g., *"including inter professional (sic) discussions in class,"* and *"discussion with my intern about the importance of collaboration"*). A third participant provided slightly more detail, saying

> *After hearing the large group discussions, I plan to discuss with my students the roles of various team members so they have a better understanding of what each member brings to the table.*

Interestingly, one participant said they would work with their field supervisor on IPE, and that they plan to *"discuss with (their) field supervisor on her role."*

26 (24.5%) participants said they plan to immediately some aspect of what they learned in the webinar on role communication and clarification. Some participants offered short comments, saying they plan to implement *"communication"* and *"want to work more on collaboration."* Others provided more detailed responses, focusing on the importance of keeping an open mind and also on self-advocacy. Let us first turn to the importance of keeping an open mind. Two participants provided detailed responses to this question, saying that they were going to try and keep an open mind about collaborating with others, and learning to value what others bring to the table. One participant stated

> *I feel there was a lot of information presented that I could apply immediately. As an MSW student and Graduate Assistant, I am constantly working in team environments with professionals in varying fields. I feel that this presentation provided good insight into how to work collaboratively and its benefits. I hope to implement increased collaboration between myself and the other professionals that I work with and to encourage an open mind to other ideas that may not have been on one's radar.*

Another participant responded

> *I was recently given the opportunity to do a "ride along" with a police department in Lancaster County this Saturday. I anticipate some resistance working with law enforcement. However, I plan to remain teachable and ready to provide insight on what my role within this opportunity is.*

Both these participants not only felt that IPE was a valuable approach to providing behavioral health services, but they felt that this training taught them the importance of having an open mind and being willing to entertain ideas and perspectives different from their own.

An overwhelming number of participants talked about their plans to implement clear communication, especially in clarifying the roles and expertise of team members. For instance, one respondent said they planned to *"implement conversations clarifying the role and values – just improved communication"* while another participant said they *"plan to utilize (their) understanding that individuals are coming from their education with a profession-centric mindset and may have misconceptions about other professions that could lead to conflict; (and) to approach conflict resolution with empathy and humility."* Yet a third participant said that they plan to *"(validate) importance of each member of the team and that all bring something that enhances outcomes for those with whom (they) work."*

More specifically, several participants also focused on the need for self-advocacy, especially in situations where others might not understand their background and expertise. One participant said that they plan to *"(speak) more about (their) role to other professionals,"* while another said they plan to *"contribute more at meetings."* Some participants honed in more on the need for self-advocacy.

> *I plan on advocating for myself more as a professional. I would also like to implement more boundary setting into my professional career.*
>
> *I will advocate for myself in my internship and make sure that I ask questions when I need clarification.*
>
> *I plan to take more of a vocal role on the teams I sit on, especially when advocating for children, youth, and families.*
>
> *Speaking up more. Some of our inter-disciplinary meetings are held virtually and it gets frustrating because everyone speaks up at once or goes on a tangent but for me to remember what my goal is and to speak up about what I think is important for the client/patient.*
>
> *I think I may send out a clarification of social work roles on our team, because there is a lot of confusion. I think understanding our scope of practice is setting good boundaries.*

As can be seen from the last response, the majority of the comments on self-advocacy came from participants with a background in social work. There is a strong sense that in a team setting, social work and social workers might not be respected to the same degree as those from other backgrounds, and hence, social workers need to be assertive about clarifying their roles and emphasizing their important contributions to the team.

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training was overwhelmingly positive. Participants provided positive feedback, and appreciated the webinar incorporated the formats of breakout groups and extensive examples from lived professional experiences. There were two respondents who commented that the webinar was too general and geared towards students, but in the larger picture, this approach seemed appropriate for the audience as a whole. Looking ahead, it will be interesting to see if the responses from the team-based surveys will be different for this cohort, compared to last year's cohort. The 2021-2022 cohort did not have many questions or feedback about team-based approaches, but they also did not have an opportunity for an in-depth webinar training. The 2022-2023 cohort are starting off with a webinar training on IPE, and it will be interesting to see if their responses to the team-based surveys are more in-depth and thoughtful.

APPENDIX C
GOAL #3 OBJECTIVE 3(B)
FALL 2022 "Supporting Children with Complex Emotional and Sensory Needs" Webinar Evaluation

Sample Size

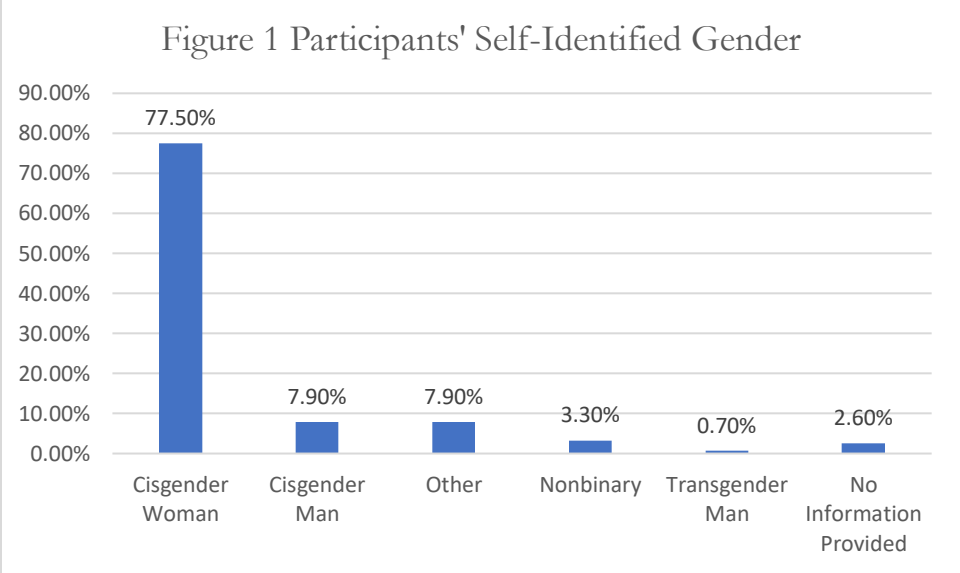
For this webinar training, 63 respondents only filled out the pre-test survey, 17 respondents only filled out the post-test survey, and 88 respondents completed both pre- and post-test surveys. A

few respondents completed the same survey twice. For these individuals, we included the first survey they completed, and discarded the second.

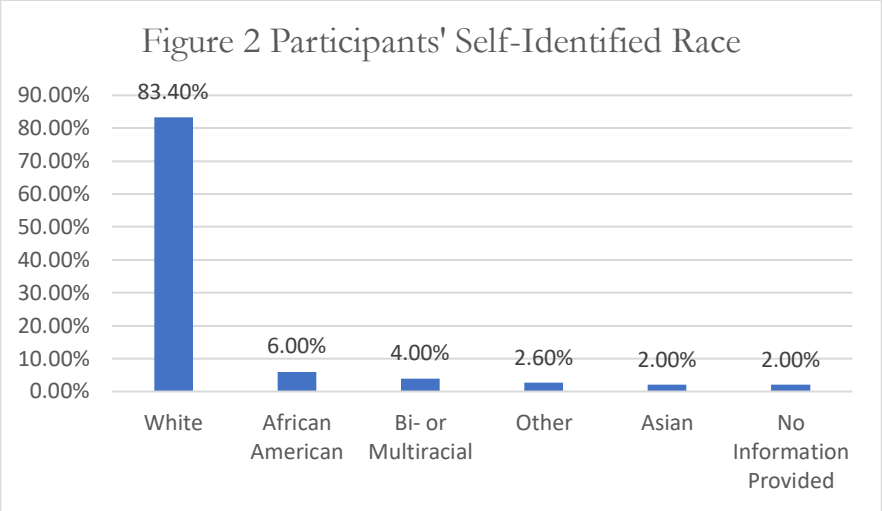
Demographics (Based on the Pre-Test Survey)

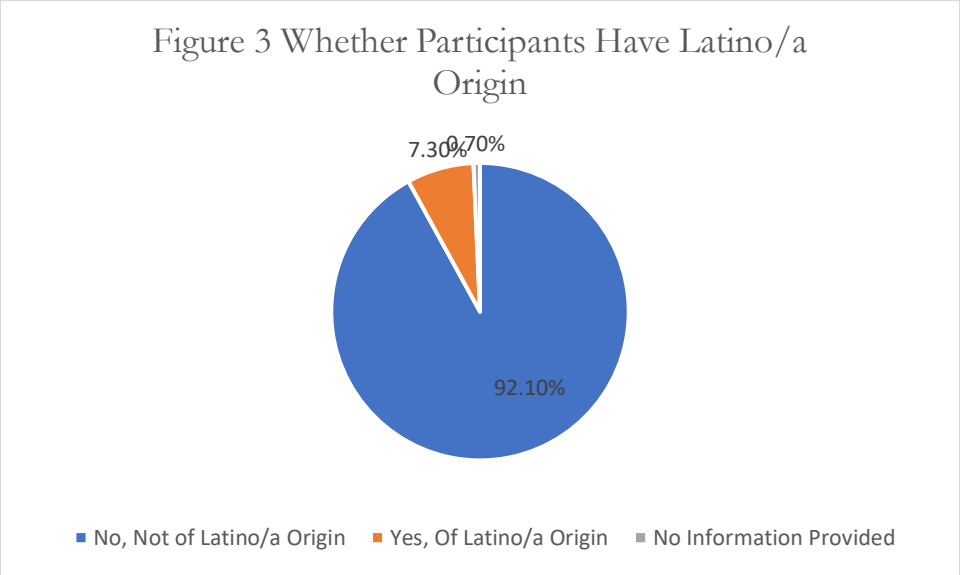
As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, and which program, if any, they were affiliated with at Millersville University. Lastly, they were also asked how many years they had worked in behavioral health. **Overall, the sample size was 151 participants, a majority of whom identified as cisgender women, white, not of Hispanic, Latino/a or Spanish ancestry, and straight. The most common status that participants identified was as a community provider, and 45% of participants identified an affiliation with the Social Work program. Finally, participants stated a mean 11.19 years of experience in a social work-related or behavioral healthcare field.**

The pre-test sample included 117 (77.5%) respondents who identified as cisgender women, 12 (7.9%) who identified as cisgender men, 12 (7.9%) as other, five (3.3%) as nonbinary, and one (0.7%) as a transgender man. 4 (2.6%) respondents did not provide a response for this demographic variable (see Figure 1).

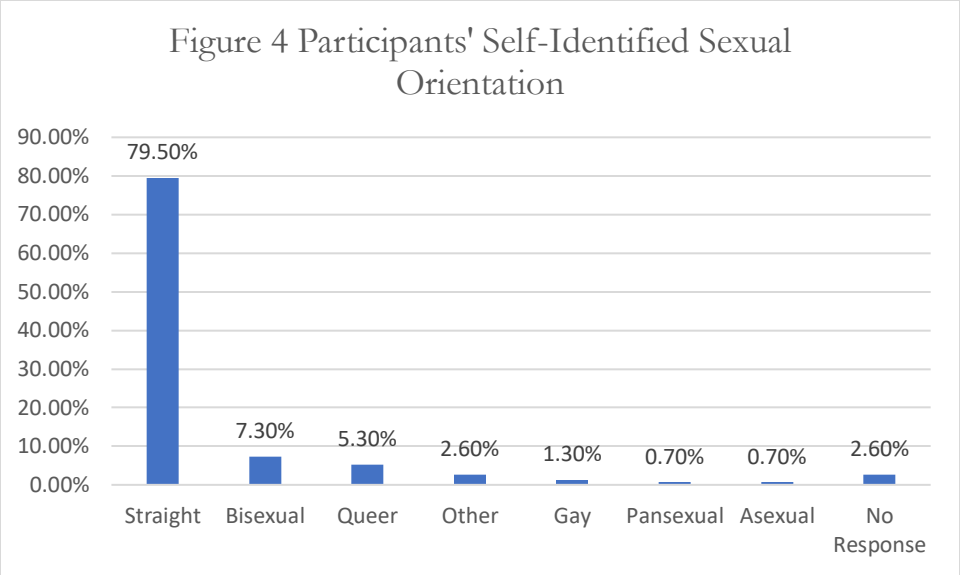


126 (83.4%) webinar participants self-identified as White, nine (6.0%) self-identified as African American, six (4.0%) self-identified as bi- or multicultural, four (2.6%) identified as other, and three (2.0%) identified as Asian. Three (2.0%) respondents did not provide a response for this demographic variable (see Figure 2). 139 (92.1%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 11 (7.3%) participants said they did. One (0.7%) participant did not provide a response to this demographic variable (see Figure 3).

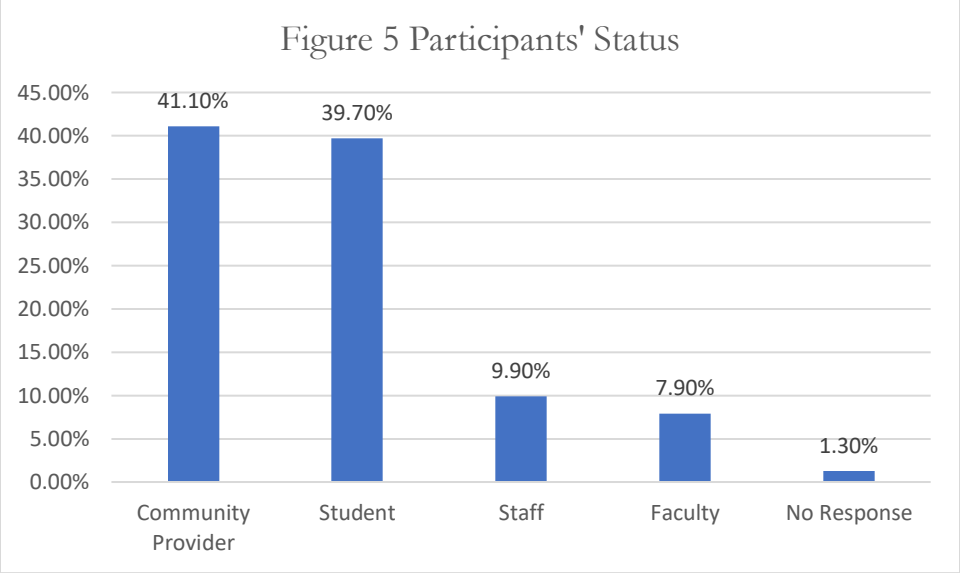




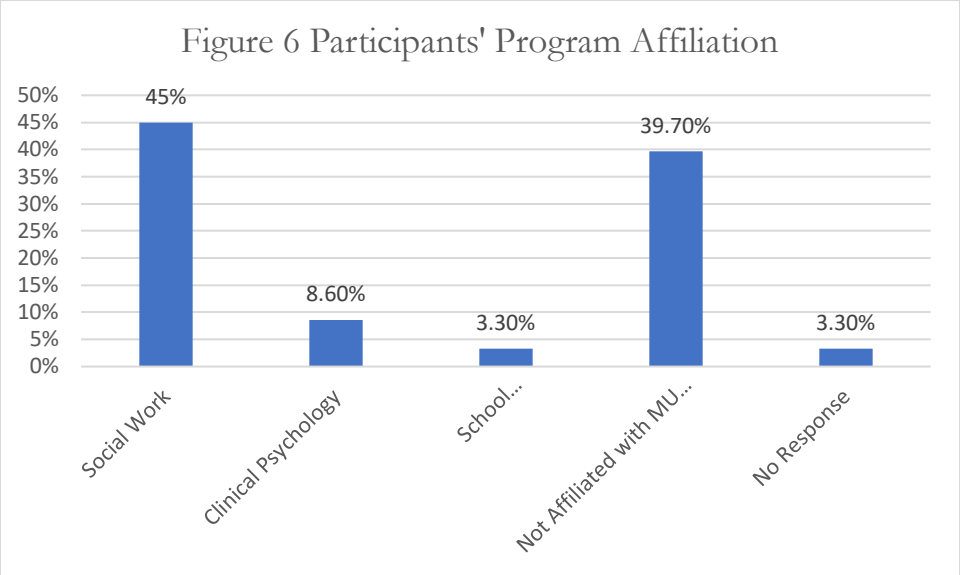
Participants also answered questions about their self-identified sexual orientation. Here, 120 (79.5%) respondents self-identified as straight, 11 (7.3%) as bisexual, eight (5.3%) as queer, four (2.6%) as other, two (1.3%) as gay, 1 (0.7%) as asexual, and 1 (0.7%) as pansexual. Four (2.6%) participants declined to provide a response for this demographic variable (see Figure 4 on the next page).



In addition to demographic questions, participants answered questions related to their status and program affiliation (if any) at Millersville University. 62 (41.1%) of the participants said they are community providers, 60 (39.7%) identified themselves as students, 15 (9.9%) identified themselves as staff, and 12 (7.9%) identified as faculty. Two (1.3%) respondents did not provide a response for this demographic variable (see Figure 5).



60 (39.7%) did not identify a MU program affiliation, while 5 (3.3%) did not provide a response to this question. 68 (45.0%) participants said they were affiliated with the Social Work department, 13 (8.6%) stated that they were affiliated with the Clinical Psychology program, and five (3.3%) stated that they were affiliated with the School Counseling / Psychology program (see Figure 6 on the next page).



Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 144 (95.4%) participants provided a response while seven (4.6%) did not do so. Responses ranged from zero to 40 years in the field and the mean was 11.19 years (*SD* = 10.478). The median years worked was 8.

Participants' Perceptions of the Presenter and Training

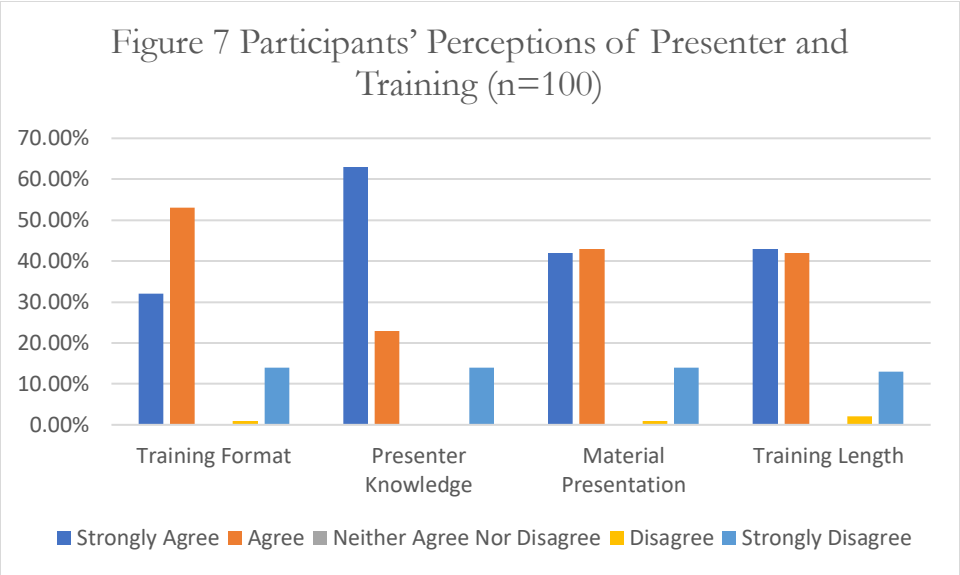
Four questions assessing the participants' perceptions of the training were included on the post-test survey. Participants were asked to respond to each statement by selecting *strongly disagree*, *disagree*, *agree*, or *strongly agree*. Responses were provided for 100 out of 105 surveys for these four items, resulting in a response rate of 95.2%. Overall, participants were positive about the training. Out of all valid responses, 85 (85.0%) participants strongly agreed or agreed that the format for the training met their needs, while 86 (86.0%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 85 (85.0%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 85 (85.0%) participants strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7 on the next page).

Knowledge, Skills, and Attitudes About Supporting Children With Complex Emotional and Sensory Needs – Quantitative Data Analysis

In addition to questions about demographics and the training, participants were asked, in both the pre- and post-surveys, to select the best response to four statements regarding their knowledge, skills, and attitudes, about supporting children with complex emotional and sensory needs. Using a Likert scale, participants could select *strongly agree* (coded as 1), *agree* (2), *neither agree nor disagree* (3), *disagree* (4) or *strongly disagree* (5). Participants were asked to respond to four statements:

(1) I am confident in my current knowledge about supporting children with complex emotional and sensory needs.
(2) I am confident in my current skill level in supporting children with complex emotional and sensory needs.

(3) I believe that understanding and applying best practices in supporting children with complex emotional and sensory needs is an important component of practice delivery.
(4) I believe that understanding how best to support children with complex emotional and sensory needs can provide positive benefits in the delivery of practice.



Descriptive Statistics

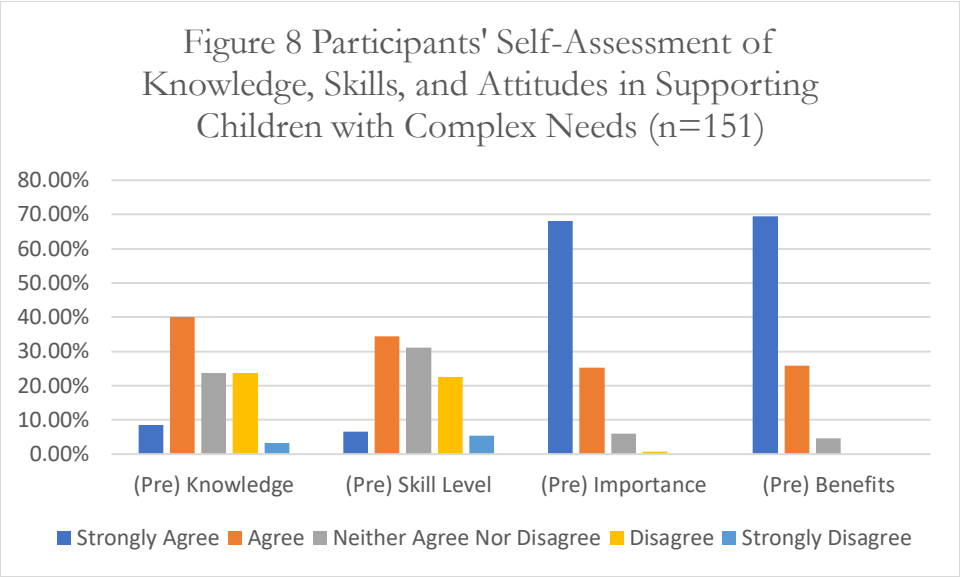
In the pre-survey, we received 151 responses for all four items. Respondents generally rated their attitudes about supporting children with complex emotional and sensory needs towards the "strongly agree" and "agree" end of the scale. In contrast, respondents seemed less sure of their knowledge and skills in this area, leaning more towards "neither agree nor disagree." Means were 2.73 for item #1, 2.85 for item #2, 1.39 for item #3, and 1.35 for item #4 (medians were 3 for items #1 and #2, and 1 for items #3 and #4). Responses leaned towards the "positive" end of the scale, as can be seen in Figure 8 (on the next page).

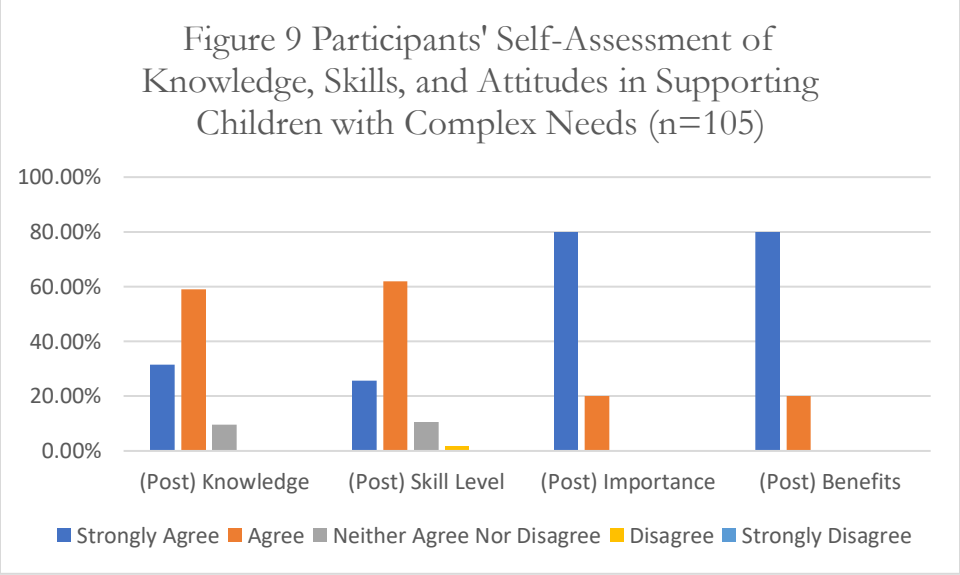
In the post-survey, we received 105 responses for all four items. In general, respondents still rated their knowledge, skills, and attitudes about supporting children with complex needs towards the "strongly agree" and "agree" end of the scale, but we see a shift towards the more positive end, particularly for items #1 and #2. Means were 1.78 for item #1, 1.89 for item #2, 1.20 for item #3, and 1.20 for item #4 (medians remained the same – 2 for items #1 and #2, and 1 for items #3 and #4) (see Figure 9 on the next page).

Inferential Statistics

For this webinar, we matched 88 respondents who completed both the pre- and post-webinar surveys. A two-tailed, t-test for dependent samples was run for each pair of statements for these 88 respondents to determine if their mean changes in responses were statistically significant. Overall, we see statistically significant changes for the first two items in a "positive" direction (moving towards the "strongly agree" end of the scale). Items #3 and #4 were not statistically significant. However, it should be noted that the pre-means were already very positive, and while there were positive changes in the post-means, there wasn't much room to improve, so to speak.

The magnitudes of the webinar's effects were also large, as Cohen's d was 0.905 and 0.915 for items #1 and #2 respectively (following a guideline of 0.8 as indicating a large effect) (see Table 1 on the following page).





Post-Webinar Qualitative Data Analysis

In the post-survey, we posed two open-ended questions to webinar participants: (1) Which aspects of the training were most beneficial to you? and (2) What do you plan on immediately implementing as a result of attending the training? Below, we provide a summary of participants' feedback and responses. 95 (90.5% of post-webinar participants) participants provided responses to the first question, while 93 (88.6% of post-webinar participants) participants provided responses to the second question.

Table 1 **Dependent Samples T-Test Results for Fall 2022 "Supporting Children with Complex Needs" Webinar (n=88)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about supporting children with complex emotional and sensory needs.	2.68	1.77	< 0.001
I am confident in my current skill level in supporting children with complex emotional and sensory needs.	2.83	1.86	< 0.001
I believe that understanding and applying best practices in supporting children with complex emotional and sensory needs is an important component of practice delivery.	1.35	1.20	0.052
I believe that understanding how best to support children with complex emotional and sensory needs can provide positive benefits in the delivery of practice.	1.27	1.22	0.320

Most Beneficial Aspects of the Training

Participants' responses for this question fell into two broad categories: (1) the format of the webinar; and (2) the content of the webinar. Overall, participants' responses were overwhelmingly positive, with several participants indicating that they found the webinar to be of tremendous benefit overall. For instance, one participant responded *"the material was well presented"* when asked which aspects of the training were most beneficial, while another participant said *"(i)t was very relatable, held my interest."* A third participant responded they found the entire training to be helpful, and that they *"liked the flow of the presenters; it seemed very knowledge based and not just reading from the slide (sic)."* A fourth participant provided a comment that best reflected the overall positive feedback that participants offered, *"I am grateful that this information is being share (sic) with more and more future mental health clinicians.*

It helps to build more empathy for kids struggling with self-regulation." The majority of the comments were also very general, focusing more on broad themes and areas.

There was one specific aspect of the webinar's format that participants singled out as being beneficial – the examples and intervention recommendations provided by the presenters. Several (10; 10.5%) participants said that that they found the use of examples to be particularly valuable. Three participants stated that they found the *"case examples,"* to be most beneficial, while a fourth participant said that they appreciated the *"(h)ands on ideas for adapting activities to meet sensory needs."* A fifth participant's comment summed up the appeal of the webinar format nicely.

> *I haven't really worked with children before and this training helped me understand what it's like to work with children with complex emotional and sensory needs. What I really liked about the training is that the instructor had first hand experience and they were able to tell us what they do when they come across children with these needs.*

As for the content of the webinar, participants identified three key themes to be of major benefit: (1) the effects of childhood trauma; (2) sensory systems and self-regulation; and (3) the brain. Most comments also incorporated at least two of these three key themes, e.g., finding the discussion of the impact of childhood trauma on the brain to be beneficial.

First, many (34; 35.8%) participants discussed what they learned about childhood trauma and its effects to be highly beneficial. Some of these comments were general and broad, e.g., one participant said that *"learning about trauma"* was helpful, while another said that the *"trauma information"* was beneficial. A third participant said that they appreciated the opportunity to *"re-(look) at the physical implications of childhood trauma and how this might manifest in different behaviors,"* while a fourth said it was beneficial for them to learn and *"understand the effects of childhood trauma"* through this webinar. While the majority of the comments on trauma were broad and general, a few participants did highlight specific information about childhood trauma that they learned in the webinar. Below are two participants' comments that provided more detail about what they found specifically beneficial about learning about childhood trauma and its effects.

> *I really appreciated the level of depth that the presenters provided on how trauma and toxic stress impact the development of children. I also liked when they stated that an infant being removed from the home causes immediate attachment disruption. I currently intern in the Children's Advocacy Clinic with adjudicated dependent youth, so that information was beneficial to me.*

> *I found it very helpful to hear that children who experience trauma may become overwhelmed by the way classrooms are traditionally decorated with bright colors and lots of pictures around. Although I do not plan to work in a classroom setting, it is still important to consider when I have my own office.*

Second, many participants (28; 29.5%) said they found the webinar's focus on the sensory system to be beneficial. Several provided general and broad comments, e.g., saying that they found *"all the different sensory kinds of awareness that were explained"* and *"discussing the various types of sensory input"* to be most beneficial. These were the common types of comments offered in response to the webinar content on the sensory system. One participant did provide a more specific comment, stating that they *"loved the specific sensory strategies shared,"* honing in on the intervention recommendations. Similarly, another participant also honed in on the intervention

recommendations, stating that they found *"ways to help especially younger children with sensory/regulation needs"* to be a beneficial aspect of the webinar. Two participants shared more detailed appreciation of what they learned from the webinar, as can be seen below:

> *The overall presentation was beneficial in understanding how trauma and sensory needs can impact caring for children. I thought it was very beneficial to hear the various ways that children can struggle with their environment and interactions.*

> *I have attended several trauma and infant and early childhood mental health trainings, but this was the first training that highlighted both emotional and sensory needs. Thank you for the very informative and thorough training!*

Finally, many participants (22; 23.2%) also highlighted what they learned about the brain to be the most beneficial aspect of the training. As with the previous two content areas, many (in fact, almost all) of the comments for this third content area were broad and general, including *"brain development and trauma relationship," "I learned a lot more about trauma and its relation to the brain,"* and *"learning about different parts of the brain."* Participants often highlighted learning about the impact of trauma on brain development to be of benefit to them, as can be illustrated from this participant saying that, *"learning and understanding how trauma plays a significant role in sensory function/brain development and how trauma ties into development"* was the most beneficial aspect of the training.

Implementation

The participants' responses on what they plan to immediately implement as a result of the telehealth training focused on three main areas: (1) developing awareness; (2) educating others; and (3) utilizing specific recommended interventions. Of note, several participants also noted that they do not work with children, but plan to consider how to adapt the information from this webinar for their adult clients.

27 (29.0%) participants commented that participating in this webinar training had given them a keener understanding and awareness of the impact of trauma, and that they plan to bring this new understanding towards their work. For instance, one participant said that they would *"be more aware of the warning signs,"* while another said that they *"plan to be more aware of the impacts of sensory seeking/overstimulation in regards to the different senses, especially for (their) clients in daycare settings."* A third participant said that they *"will make sure that (they are) extremely vigilant in (their) observation of a child's behavior; (m)aking sure to not only get the surface level behavioral observations, but also the subtle, deeper meaning behind those observations."* In a similar vein, a fourth participant commented

> *Reflecting on this training, I am able to realize that when an individual becomes overwhelmed in a loud or energetic atmosphere, it does not always mean they are on the spectrum. This training taught me that those who experience trauma also get overstimulated and overwhelmed. This is a lesson I can immediately start applying as a way of being aware of other things someone might be experiencing that is influencing their behaviors."*

While the comments on bringing their new awareness to their work tended to be general and broad, one participant did provide a specific example of how they would implement their new awareness, saying that they would *"reinforce the trauma informed approach and language regarding what has happened to someone versus what is "wrong" with someone."*

Eleven (11.8%) participants said they would share what they have learned and educate others when asked what they immediately plan to implement, with one saying they plan to *"share ideas with staff who directly support children,"* while another said they plan to *"share the significance of meeting sensory needs to colleagues and families."* A third participant said they would *"share content with colleagues,"* while a fourth said they would *"be more intentional with sharing the significance of meeting sensory needs."* Again, while several of the comments were broad and general in nature, one participant was more specific about how they planned to educate others and share what they had learned:

> *I want to be able to share with teachers and help them understand the reasoning behind students' behavior and recognize certain behaviors the students do are actually going to benefit them and not hinder them in the classroom. For example, a student walking out of class to calm down instead of exploding in the classroom.*

Finally, five (5.4%) participants focused on specific interventions that they would immediately implement. These comments typically focused very narrowly on a specific intervention they learned about in the webinar, and were sometimes contextualized within a larger context of the respondent's workplace and setting. For instance, one respondent said they planned to use calming music, while another said they planned to *"incorporate senses in all therapy as well as play to engage children."* A third respondent commented that they *"had used rain sounds before and never thought about how the unpredictability of it can trigger children,"* and that they planned to *"try more predictable sounds like a sound machine noise."* The final two respondents situated their planned implementation within the context of their specialty and workplace, with one commenting that they were an education major and *"found the information on how to implement examples like sensory bins and swinging to be the most helpful."* The final respondent in this group said that they planned to *"find ways to make (their) play therapy room less visually overwhelming."*

CONCLUSION

As mentioned earlier, and like the first webinar training for the 2022-2023 cohort, the response and feedback from participants to this webinar training was overwhelmingly positive. Participants provided positive feedback, and appreciated the webinar's incorporation of extensive examples from lived professional experiences. In the pre-survey, participants scored very positively on the survey items focusing on attitudes and beliefs, and while these scores improved in the post-survey, the changes were not statistically significant. By contrast, we found positive statistically significant changes in the survey items focusing on knowledge and skills. Pairing the survey scores with the open-ended survey comments, it is clear that while participants came to the webinar already convinced of the importance and value of supporting children with complex emotional and sensory needs, they were able to leave with higher levels of confidence in their knowledge and skills.

APPENDIX D
GOAL #3 OBJECTIVE 3(B)
SPRING 2023 "Trauma Informed Communities" Webinar Evaluation

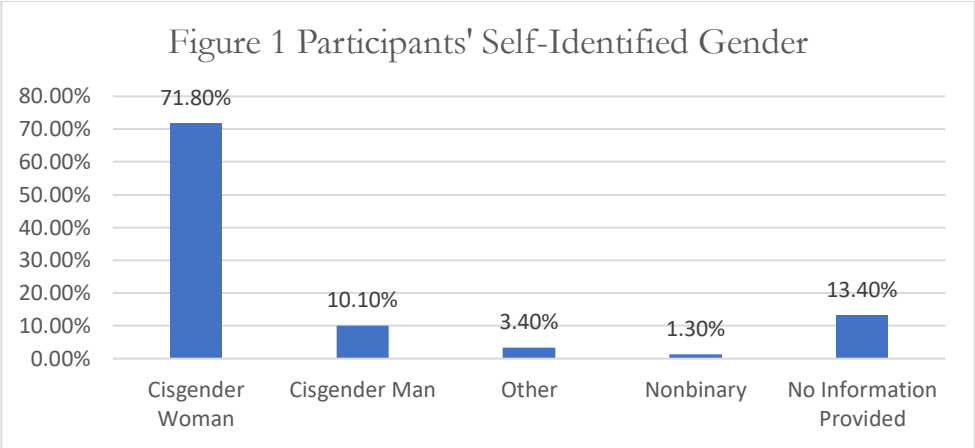
Sample Size

For this webinar training, 49 respondents only filled out the pre-test survey, 18 respondents only filled out the post-test survey, and 82 respondents completed both pre- and post-test surveys. Quite a few respondents completed the same survey twice (or more). For these individuals, we included the first survey they completed, and discarded the second.

Demographics (Based on the Pre-Test Survey)

As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, and which program, if any, they were affiliated with at Millersville University. Lastly, they were also asked how many years they had worked in behavioral health. **Overall, the sample size was 130 participants, a majority of whom identified as cisgender women, white, not of Hispanic, Latino/a or Spanish ancestry, and straight. The most common status that participants identified was as a community provider, and 43.7% of valid participants identified an affiliation with the Social Work program. Finally, participants stated a mean 12.03 years of experience in a social work-related or behavioral healthcare field.**

The pre-test sample included 107 (71.8%) respondents who identified as cisgender women, 15 (10.1%) who identified as cisgender men, 5 (3.4%) as other, and two (1.3%) as nonbinary. 20 (13.4%) respondents did not provide a response for this demographic variable (see Figure 1).



104 (69.8%) webinar participants self-identified as White, 11 (7.4%) self-identified as African American, seven (4.7%) self-identified as bi- or multicultural, four (2.7%) identified as Asian, three (2.0%) identified as other, and one (0.7%) identified as American Indian or Alaska Native. 18 (12.1%) respondents did not provide a response for this demographic variable (see Figure 2). 120 (80.5%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or

Spanish ancestry, while 10 (6.7%) participants said they did. 18 (12.1%) participants did not provide a response to this demographic variable (see Figure 3).

Figure 2 Participants' Self-Identified Race

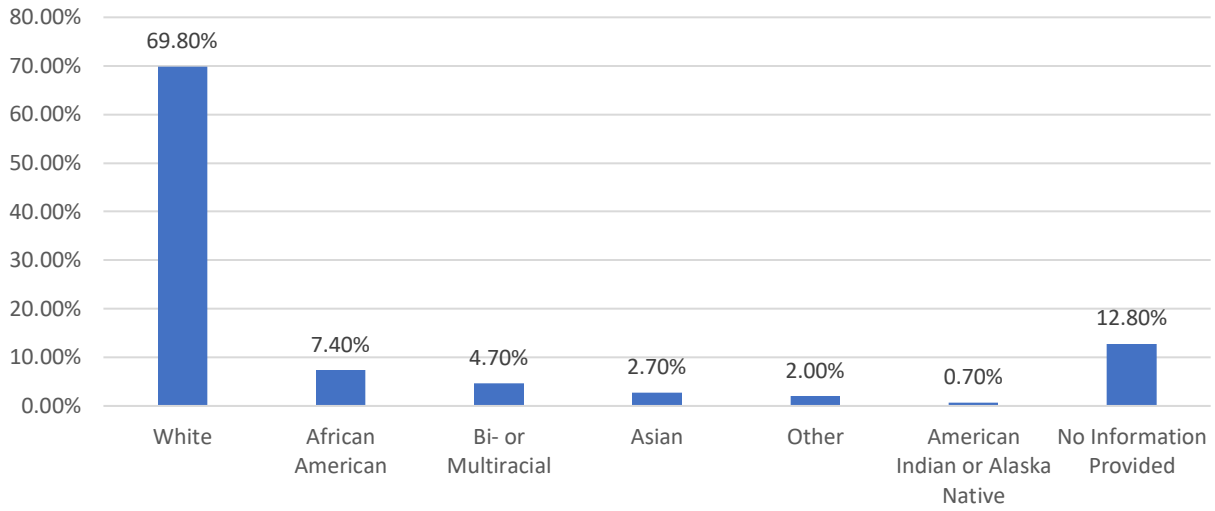
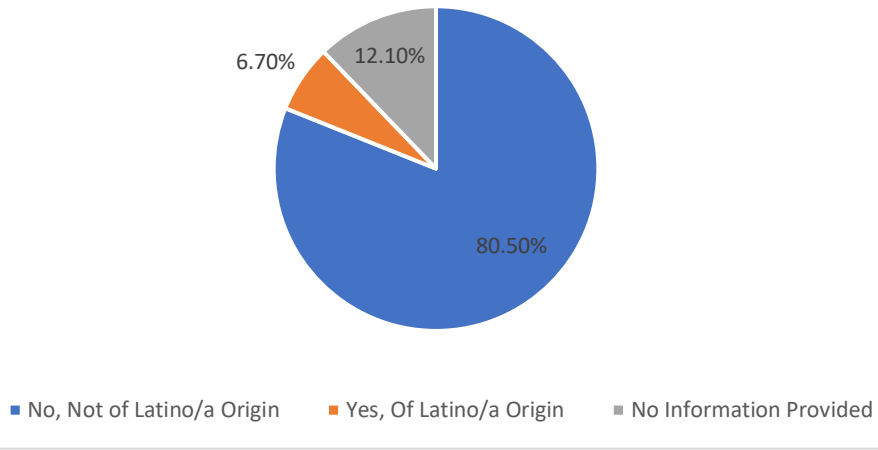
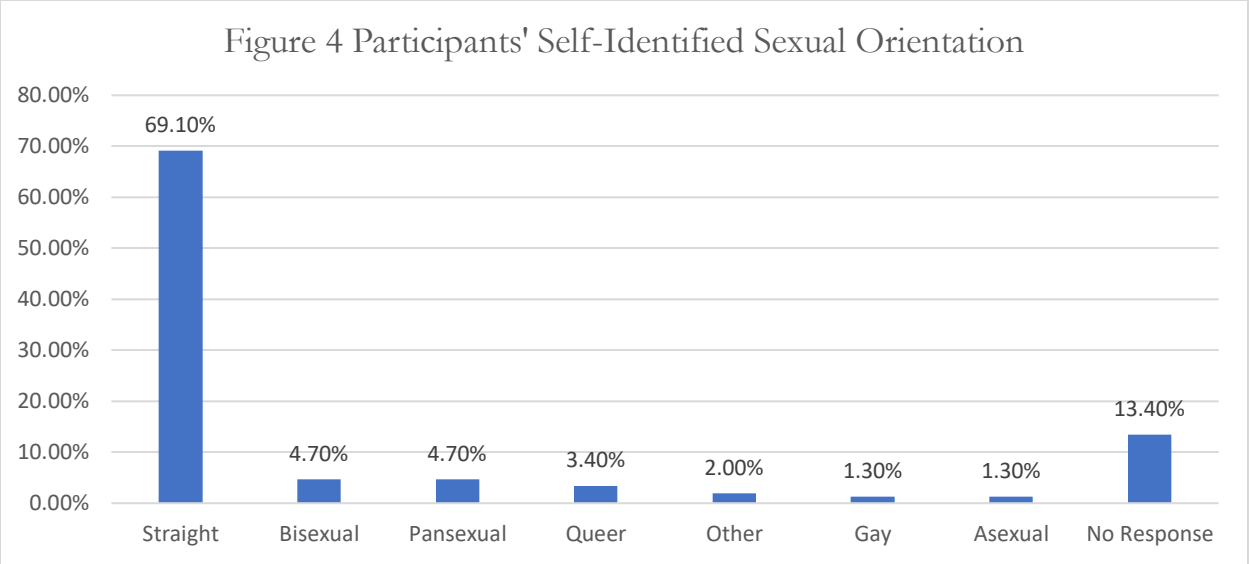


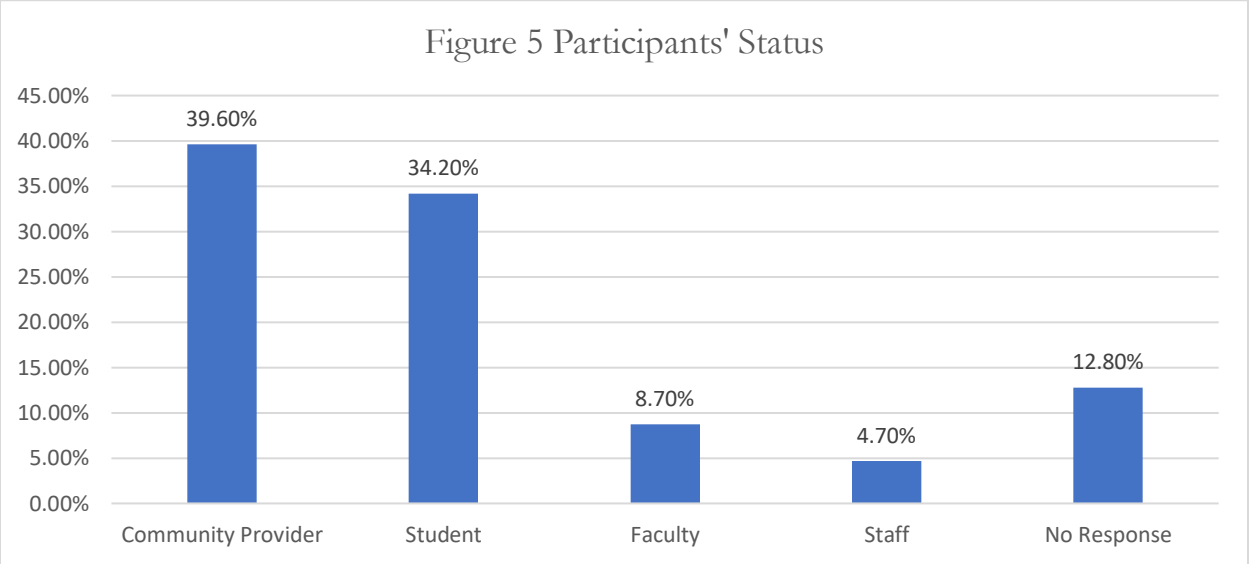
Figure 3 Whether Participants Have Latino/a Origin



Participants also answered questions about their self-identified sexual orientation. Here, 103 (69.1%) respondents self-identified as straight, seven (4.7%) as bisexual, seven (4.7%) as pansexual, five (3.4%) as queer, three (2.0%) as other, two (1.3%) as gay, 1 (0.7%) as lesbian, and 1 (0.7%) as asexual. 20 (13.4%) participants declined to provide a response for this demographic variable (see Figure 4).

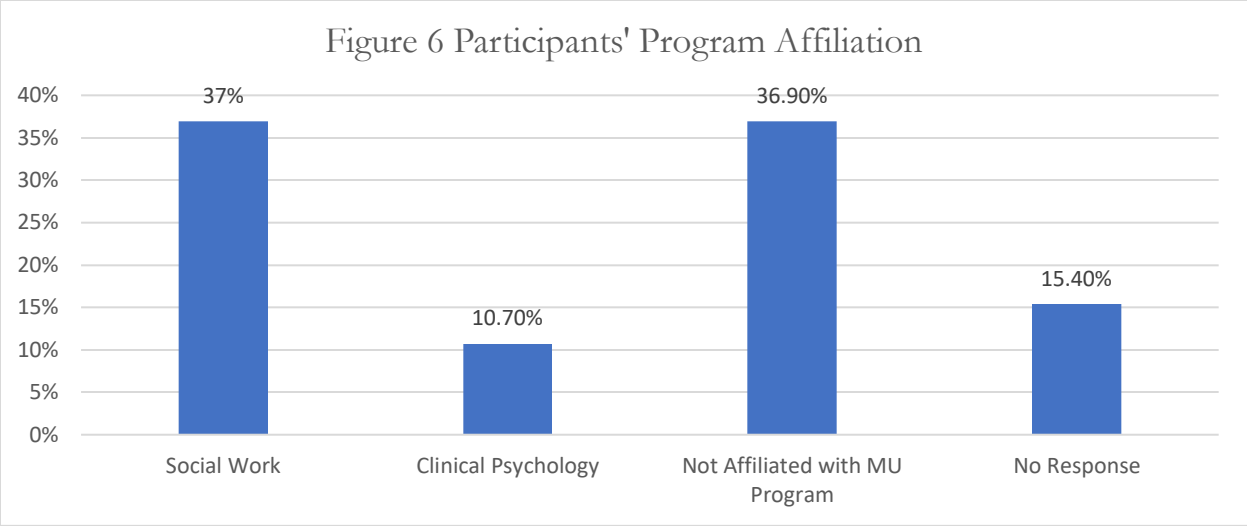
In addition to demographic questions, participants answered questions related to their status and program affiliation (if any) at Millersville University. 59 (39.6%) of the participants said they are community providers, 51 (34.2%) identified themselves as students, 13 (8.7%) identified themselves as faculty, and seven (4.7%) identified as faculty. 19 (12.8%) respondents did not provide a response for this demographic variable (see Figure 5 on the next page).





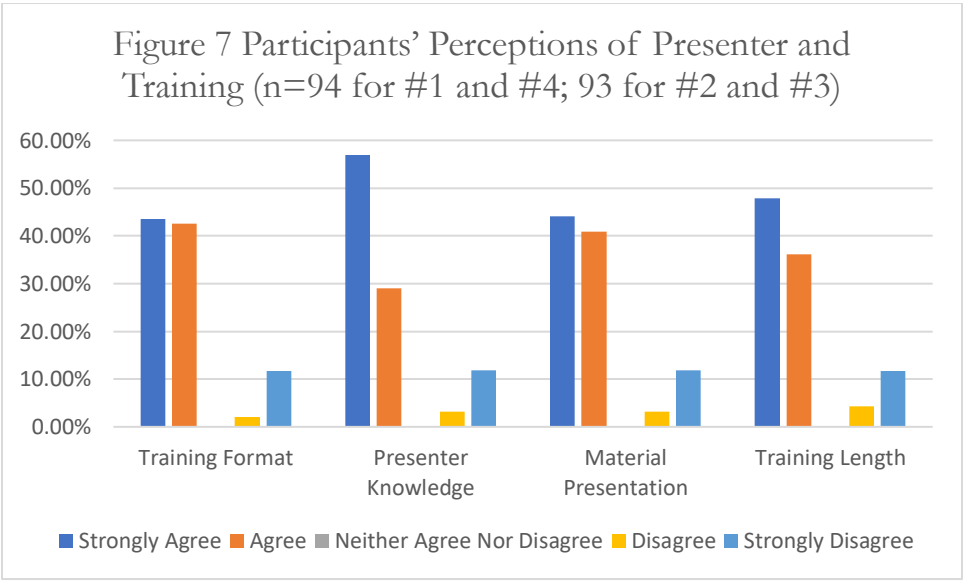
55 (36.9%) did not identify a MU program affiliation, while 23 (15.4%) did not provide a response to this question. 55 (36.9%) participants said they were affiliated with the Social Work department, and 16 (10.7%) stated that they were affiliated with the Clinical Psychology program (see Figure 6 on the next page).

Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 126 (84.6%) participants provided a response while 23 (15.4%) did not do so. Responses ranged from zero to 40 years in the field and the mean was 12.03 years (SD = 10.361). The median years worked was 10.



Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included on the post-test survey. Participants were asked to respond to each statement by selecting *strongly disagree*, *disagree*, *agree*, or *strongly agree*. Responses were provided for 93 out of 100 (93%) surveys for the second and third items. For the first and fourth items, responses were provided for 94 out of 100 (94%) surveys. Overall, participants were positive about the training. Out of all valid responses, 81 (86.2%) participants strongly agreed or agreed that the format for the training met their needs, while 80 (86.0%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 79 (84.9%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 79 (84.0%) participants strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7).



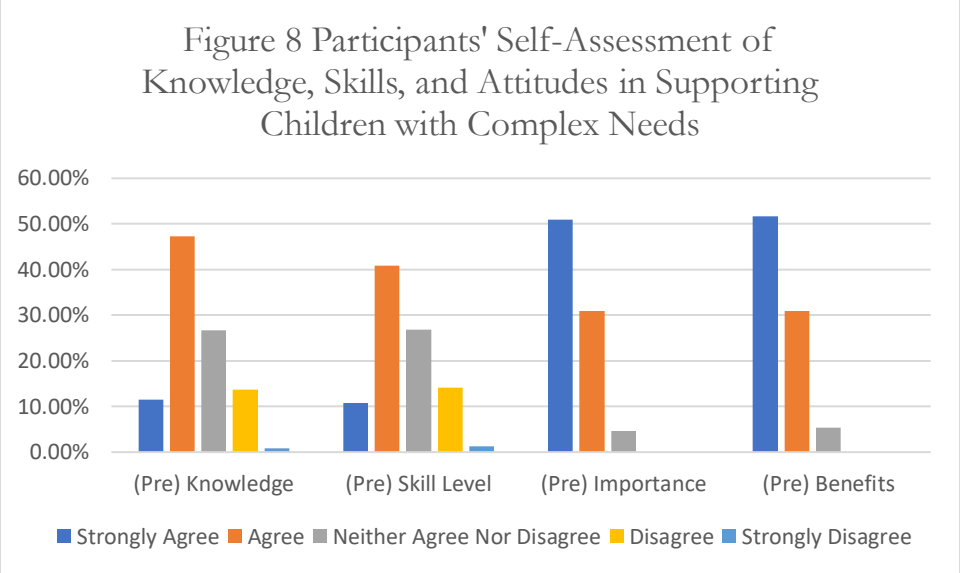
Knowledge, Skills, and Attitudes About Trauma Informed Communities – Quantitative Data Analysis

In addition to questions about demographics and the training, participants were asked, in both the pre- and post-surveys, to select the best response to four statements regarding their knowledge, skills, and attitudes, about trauma informed communities. Using a Likert scale, participants could select *strongly agree* (coded as 1), *agree* (2), *neither agree nor disagree* (3), *disagree* (4) or *strongly disagree* (5). Participants were asked to respond to four statements:

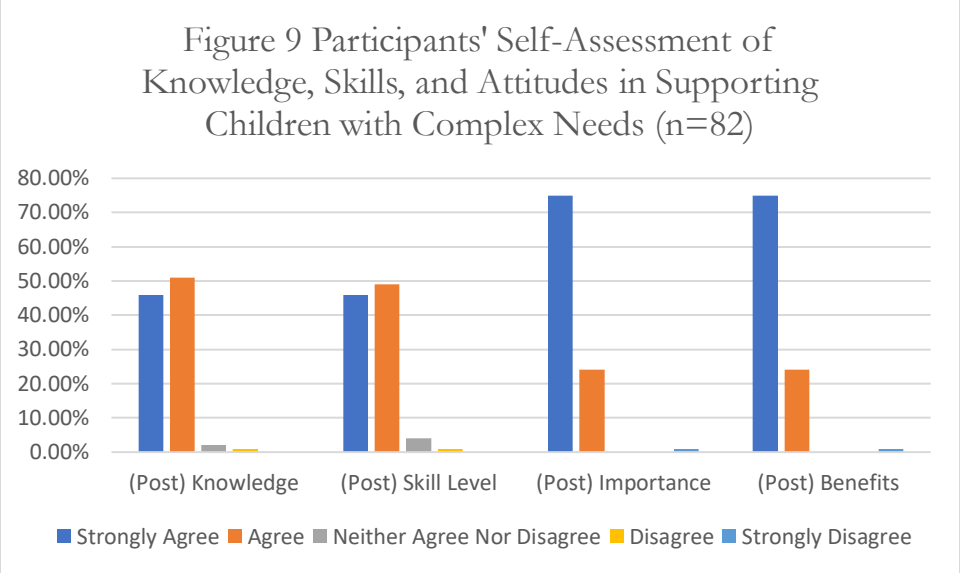
(5) I am confident in my current knowledge about using a trauma informed lens to inform policy changes and to advocate for change.
(6) I am confident in my current skill level in using a trauma informed lens to inform policy changes and to advocate for change.
(7) I believe that understanding and applying best practices in using a trauma informed lens to inform policy changes and to advocate for change is an important component of delivery practice.
(8) I believe that understanding how best to use a trauma informed lens to inform policy changes and to advocate for change can provide positive benefits in the delivery of practice.

Descriptive Statistics

In the pre-survey, we received 131 valid responses for items #1 and #4, 130 responses for item #2, and 129 responses for item #3. Respondents generally rated their attitudes about supporting children with complex emotional and sensory needs towards the "strongly agree" and "agree" end of the scale. In contrast, respondents seemed less sure of their knowledge and skills in this area, leaning more towards "neither agree nor disagree." Means were 2.45 for item #1, 2.85 for item #2, 1.47 for item #3, and 1.47 for item #4 (medians were 2 for items #1 and #2, and 1 for items #3 and #4). Responses leaned towards the "positive" end of the scale, as can be seen in Figure 8 (see below).



In the post-survey, we received 100 responses for all four items. In general, respondents still rated their knowledge, skills, and attitudes about supporting children with complex needs towards the "strongly agree" and "agree" end of the scale, but we see a shift towards the more positive end, particularly for items #1 and #2. Means were 1.58 for item #1, 1.60 for item #2, 1.28 for item #3, and 1.28 for item #4 (medians remained the same – 2 for items #1 and #2, and 1 for items #3 and #4) (see Figure 9).



Inferential Statistics

For this webinar, we matched 82 respondents who completed both the pre- and post-webinar surveys. A two-tailed, t-test for dependent samples was run for each pair of statements for these 82 respondents to determine if their mean changes in responses were statistically significant. Overall, we see statistically significant changes for all four items in a "positive" direction (moving towards the "strongly agree" end of the scale). The magnitudes of the webinar's effects were large for items #1 and #2, as Cohen's d was 0.970 and 0.918 respectively. The effects were more moderate for items #3 and #4, as Cohen's d was 0.719 and 0.699 respectively (following a guideline of 0.8 as indicating a large effect) (see Table 1 on the following page).

Post-Webinar Qualitative Data Analysis

In the post-survey, we posed two open-ended questions to webinar participants: (1) Which aspects of the training were most beneficial to you? and (2) What do you plan on immediately implementing as a result of attending the training? Below, we provide a summary of participants' feedback and responses. 98 (98.0% of post-webinar participants) participants provided responses to the first question, while 93 (93.0% of post-webinar participants) participants provided responses to the second question.

Table 1 Dependent Samples T-Test Results for Spring 2023 "Trauma Informed Communities" Webinar (n=82)

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about supporting children with complex emotional and sensory needs.	2.39	1.57	< 0.001
I am confident in my current skill level in supporting children with complex emotional and sensory needs.	2.46	1.61	< 0.001
I believe that understanding and applying best practices in supporting children with complex emotional and sensory needs is an important component of practice delivery.	1.43	1.26	0.047
I believe that understanding how best to support children with complex emotional and sensory needs can provide positive benefits in the delivery of practice.	1.43	1.26	0.030

Most Beneficial Aspects of the Training

As with the previous webinars, participants' responses for this question fell into two broad categories: (1) the format of the webinar; and (2) the content of the webinar. Overall, participants' responses were very positive, with several participants indicating that they found the webinar to be of tremendous benefit overall. For instance, one participant responded *"(t)his was an amazing form to present a trauma informed training"* when asked which aspects of the training were most beneficial, while another participant said *"all of it."* A third participant responded they found the entire training to be "*very helpful overall*, and that they *"especially appreciated the emphasis of vicarious trauma towards the end as a reminder to us who are in the helping professions."* A fourth participant provided a comment that best reflected the overall positive feedback that participants offered, *"(t)his was an eye-opening discussion that will encourage me to be more mindful and aware of my demeanor."*

The majority of the comments were also very general, focusing more on broad themes and areas. However, participants identified three key themes to be of major benefit: (1) the general principles of trauma-informed care; (2) implementing trauma-informed care; and (3) the importance of self-care. Many comments also incorporated at least two of these three key themes, e.g., being reminded of the importance of self-care while also learning how to implement trauma-informed care.

First, many (31; 31.6%) participants said what they learned about the general principles of trauma-informed care to be highly beneficial. Some of these comments were general and broad, e.g., one participant said that *"reminder of trauma informed care and brain breaks"* was helpful, while another said that the *"trauma information"* was beneficial. A third participant said that *"(i)t's always beneficial to learn new and different ways to engage in trauma-engaged practice,"* while a fourth acknowledged that they *"never had a proper trauma training,"* and hence, they *"really enjoyed the Principles of Trauma Informed Care"* (capital letters provided by respondent). While the majority of the comments on trauma informed care were broad and general, a few participants did highlight specific information that they learned in the webinar. Below are two participants' comments that provided more detail about what they found specifically beneficial about this training and the information on trauma informed care.

> *I think the aspects of the training that were most beneficial for me would be the information that was provided on how traumatic experiences effect (sic) everyone to varying degrees. I also found the information on prevalence to be very insightful.*

> *reviewing the adverse childhood experiences – I work with children and adolescents daily and sometimes in moments of adversity or high emotion, we sometimes forget past experiences or reasons children may be acting out. (Also) The self-care regulation model also resonated with me and something that I benefited from learning about – in the aspect of there is more to self care other than doing activities that you like. I personally struggle with leaving work at work therefore this is something I can practice.*

As noted earlier, the second except above is an example of how respondents often addressed more than one main theme that they found helpful – in this case, both the principles of trauma informed care and the importance of self-care.

Second, many participants (28; 28.6%) said they found the webinar's focus how to implement trauma informed care to be beneficial. Several provided general and broad comments, e.g., saying that they found *"learning proper trauma-informed responses (giving choices, maintaining routines, etc.)"*, *"(t)eam work opportunities and application outside of direct services,"* and "*(a)ll the information for handling people*" to be most beneficial. Three participants did provide more specific comments, focusing on the meso and macro applications of trauma informed care. One participant stated that they found the *"examples of trauma informed approach in shifting policy,"* to be most beneficial. A second participant said that they found the "*(r)eview of trauma informed practices at every level – micro, mezzo, macro*" to be beneficial, while a third participant pinpointed the benefits of "*(p)rocessing how to use a trauma-informed lens in practical settings (i.e., policy making role play scenarios)*."

Several respondents focused on how beneficial they found the discussion of implementing trauma informed care at two different levels: (1) in interacting with patients and (2) at the organizational level. One participant provided a broad comment that they found the information on "*how to work with patients*" to be helpful, while another pinpointed the information on "*how to manage*

individuals who may have ACE." A third participant found it helpful to reminded of *"ways (they) can re-traumatize clients in practice*," while a fourth similarly commented that they "*(r)realiz(ed) that many aspects of treatment can be re-traumatizing to patients/clients"* and that "*(t)his was an eye-opening discussion that will encourage (them) to be more mindful and aware of (their) demeanor.*"

At the organizational level, one participant said that they learned about "*organizational* implementation" while another took away the message that it was important to *"(c)reat(e) a safe environment in the workplace for our clients and staff,*" and that they needed to provide "*more trauma informed trainings to staff.*" Interestingly, one participant provided thoughtful feedback about partnerships and collaboration at the organizational level. She responded:

> *While I understand the importance of working with all agencies within my community, it can be difficult when there are some who seem to have entirely different goals than us at our agency. Being reminded that TIC includes strengthening those relationships was beneficial for me.*

Finally, 12 (12.2%) participants stated that the part of the training that they found to be most beneficial was the emphasis on the importance of self-care. Almost all of these comments were brief (e.g., "*(s)elf-care info*" and "*(s)elf-care wheel*"), with one participant saying that she found it helpful to "*(r)emind (her)self that it is ok to take a break*."

In terms of the webinar's format, participants singled out one aspect as being particularly beneficial – the breakout rooms (23; 23.5%) (although five (5.1%) participants said that they really enjoyed the TED talk). As with the comments on self-care, the majority of these comments were brief (e.g., "*I enjoyed the break out rooms*" and "*(t)he breakout groups and interactions*"). Two participants said that they enjoyed the opportunity the breakout rooms provided for discussion and conversation, and one said that this format was helpful for "*retaining the information*." One participant provided more detail than her fellow attendees, saying

> *I really enjoyed the breakout rooms! It allowed me the opportunity to discuss things with my peers as well as gain insight into other perspectives. The breakout rooms were amazing.*

Of note, this was the first webinar where we saw some negative feedback from participants. A small number of participants (4; 4.1%) did not find this training to be beneficial, with one saying briefly that "*(t)he training was not beneficial for me*," while a second participant said that "*(they) have to honest that this training was not the most beneficial for (them)." (They) felt the information was very general and basic."* The other two participants provided more detail, saying respectively:

> *Honestly I found the training to be poorly done; the presenter spoke in many generalizations, content was not geared to Master level or post grad participants. (t)he "Brain Rests" were unnecessary. (t)he TED was the more positive aspect (go) the program.*

> *I did not find the training advanced. I resented the time for "playing games." If this was an advanced training I suspect people would already know about self-care.*

All four participants were community practitioners, who have had several years of experience in the field. It is understandable that they might have found this training to be of

little utility. We also note that other community practitioners, similarly with extensive experience in the field, in contrast, found the training to be highly beneficial.

Implementation

The participants' responses on what they plan to immediately implement as a result of the telehealth training focused on three main areas: (1) practicing self-care; (2) incorporating trauma informed care into interactions with clients; and (3) reviewing organizational policies with trauma informed care in mind.

15 (16.1%) participants commented that they planned to continue to utilize self-care. For instance, one participant said that they would *"identify (their) self-care activities using the wheel worksheet given,"* while another said that she *"want(s) to try and improve (her) own self care habits to avoid vicarious trauma."* A third participant said that they plan to *"(u)se the Self Care Wheel with (their) supervisees*," while a fourth exclaimed, "*I am looking for a copy of that self care wheel and hanging it in my office as reminder!*" Overall, participants' comments on implementing self-care were brief and to the point.

Webinar participants furthered offered insight into how they would implement changes and modifications at two levels – micro (interaction) and meso (organizational). 27 (29.0%) participants said that they would take what they've learned from the webinar and implement it in their interactions with their clients, saying that they plan to be more thoughtful and to consider the potential impacts of trauma. One participant said that they would "*continue (to look) at (her) clients with a trauma lens*," while a second participant said she would now "*(a)sk questions differently about the client's past.*" A third participant said they would now "*(u)se a trauma informed lens to approach and treat clients*," while a fourth said they "*plan on looking for signs of trauma or the potential for re-traumatization at (their) internship with both the adolescents and adults (they) work with and to respond in a trauma-informed and empathetic manner.*" Like the comments on self-care, many of the comments for this area were general and did not provide much specific detail. Three participants, however, did go into some more detail to explain specifically how they would modify their interactions with clients:

> *I plan on using the information provided on aspects of trying not to retraumatize clients. For instance using verbiage that asks for permission rather than asking directly. I also plan to use the information provided on vicarious trauma to protect myself and make sure that I can be of maximum benefit to the clients served.*
>
> *From a micro-level perspective: using a TIC approach in conjunction w/cultural humility when working w/clients, especially marginalized populations. Understanding that they are the expert, especially in areas which I know little about, and taking societal norms/injustices into account.*
>
> *I will continue to bring awareness and advocate for the clients to assist staff members on being trauma informed. I recently encountered an inciident (sic) with an inter-professional that made a prejudgment of the client based on being in an emotional support classroom. After observing two sessions between the client and professional, we openly discussed the session after the client returned to the classroom. The professional made some comments that were judgmental and lacked empathy. I professionally avoided how he may have perceived things and offering a different approach to the third session. The inter-professional later thanked me for bringing awareness to their prejudgments and seeing things through the clients (sic) lense/perspective.*

Finally, 13 (14.0%) participants focused on reviewing how their organizations and workplaces incorporate trauma informed care principles. For example, one participant said they were

going to try to "*get (their) organization to be trauma informed*," while another said they planned to "*evaluat(e) (their) trauma informed practices*." Yet a third participant said that they hoped to work to "*mak(e) (their) office more trauma informed friendly*." A fourth participant said that as a result of this training, she planned to "*(c)onsider new ways to adopt trauma informed practices in policies and supervision practices.*"

Five participants tied their implementation plans to a wider approach to education and collaboration. One said they plan to "*discuss with colleagues"* what they have learned, and another concurred that they would *"share (to) (their) colleagues*." A third participant said they would "*(work) with (their) team on being more trauma informed*," while a fourth offered that they would "*(c)onsider new ways to adopt trauma informed practices in policies and supervision practices*." Finally, a fifth participant provided a more detailed explanation of how they plan to implement what they've learned from this webinar at a meso level, saying:

> *Sharing with my team at work the ACE's. I am the only staff member who has a background in social work and I think this could be beneficial for all staff to be aware of different types of trauma's (sic) our students may have experienced. We do incorporate trauma informed practices in our beginning of the year trainings but it would be beneficial to revisit this to better serve our students.*

What is interesting and revealing about the participants' comments is that among themselves, they have begun to consider trauma informed care at all levels of the social structure – for themselves in terms of self-care, at the micro level in their client interactions, and at the meso level in their organizational policies and procedures. While very few participants referred to the macro level, there were some references to the consideration of trauma informed care in public policy and social change as well.

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training was very positive. Participants provided positive feedback, and appreciated the webinar's extensive use of breakout rooms to facilitate conversation and discussion. We found positive statistically significant changes in all four survey items focusing on attitudes, beliefs, knowledge, and skills in regards to trauma informed principles and care. While a very small number of participants felt that the webinar training was not beneficial, the overall feedback was very positive, with many participants learning about the importance of trauma informed care and principles and how to implement them at different levels.

APPENDIX E
GOAL #3 OBJECTIVE 3(B)
SPRING 2023 "BIPOC and LGBTQIA+ Communities and the Behavioral Health Care Field" Webinar Evaluation

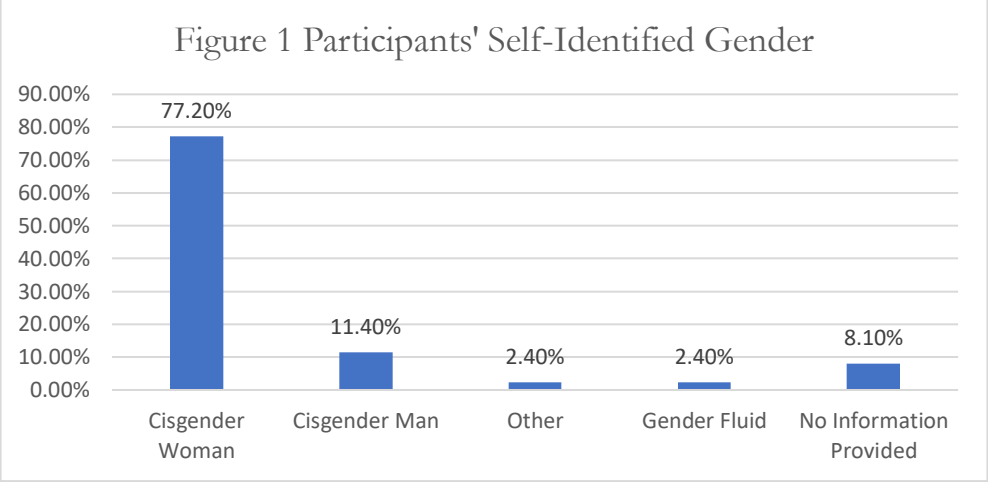
Sample Size

For this webinar training, 24 respondents only filled out the pre-test survey, 7 respondents only filled out the post-test survey, and 92 respondents completed both pre- and post-test surveys. A few respondents completed the same survey twice (or more). For these individuals, we included the first survey they completed, and discarded the second.

Demographics (Based on the Pre-Test Survey)

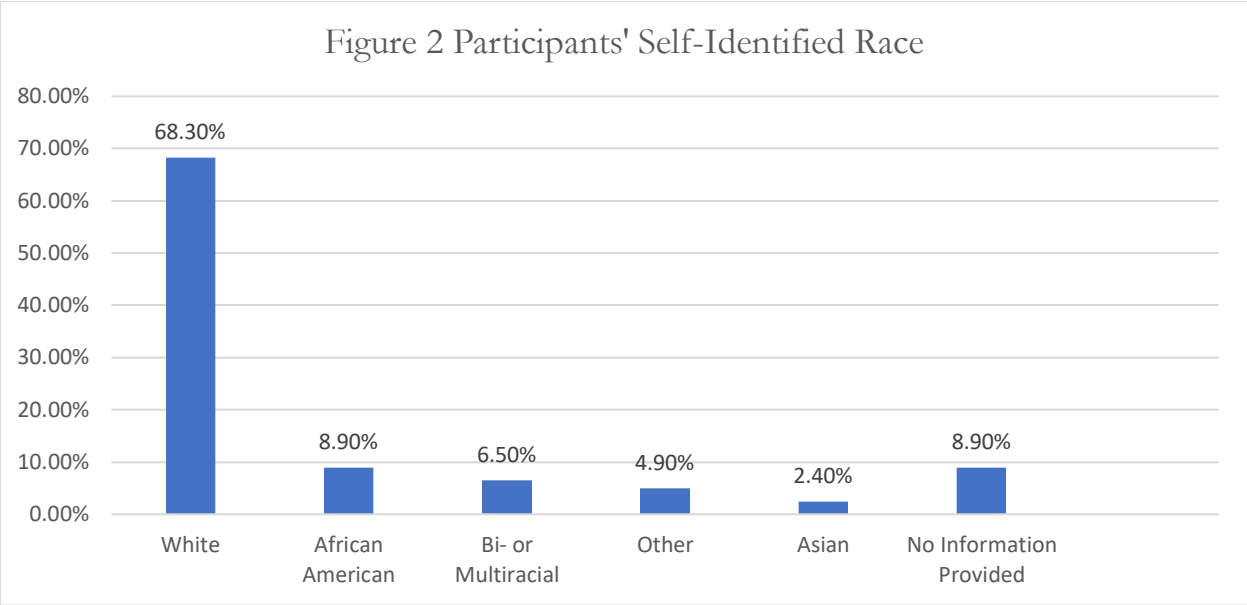
As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, and which program, if any, they were affiliated with at Millersville University. Lastly, they were also asked how many years they had worked in behavioral health. **Overall, the sample size was 123 participants, a majority of whom identified as cisgender women, white, not of Hispanic, Latino/a or Spanish ancestry, and straight. The most common status that participants identified was as a student, and 43.4% of valid participants identified an affiliation with the Social Work program. Finally, participants stated a mean 10.41 years of experience in a social work-related or behavioral healthcare field.**

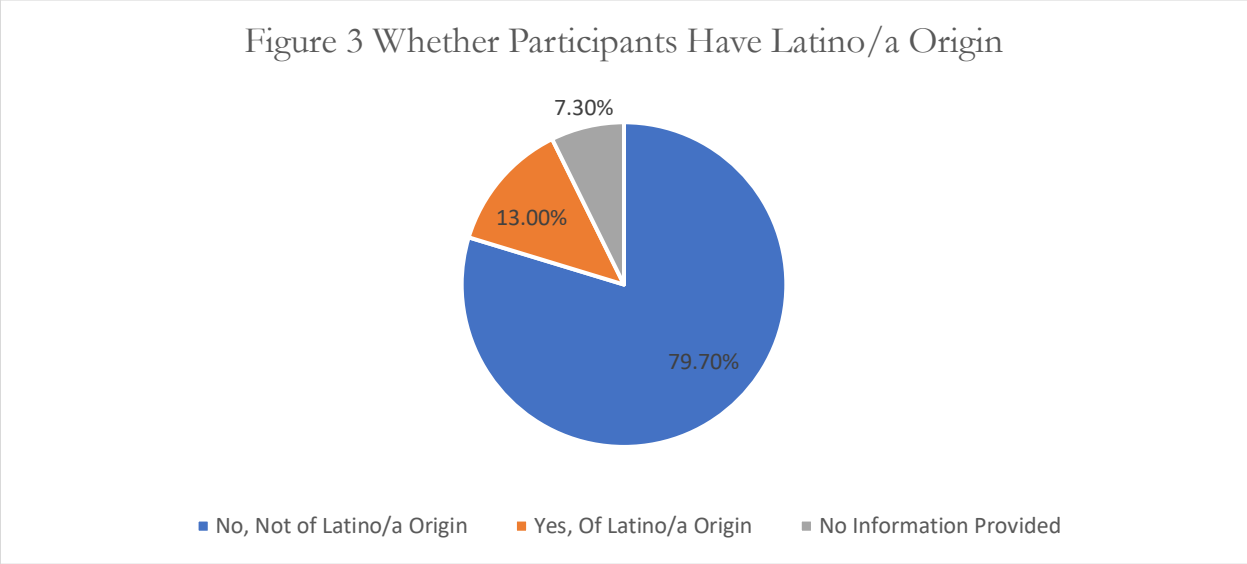
The pre-test sample included 95 (77.2%) respondents who identified as cisgender women, 14 (11.4%) who identified as cisgender men, three (2.4%) as other, and one (2.4%) as gender fluid. 10 (8.1%) respondents did not provide a response for this demographic variable (see Figure 1).



84 (68.3%) webinar participants self-identified as White, 11 (8.9%) self-identified as African American, eight (6.5%) self-identified as bi- or multicultural, six (4.9%) identified as Other, and three (2.4%) identified as Asian. 11 (8.9%) respondents did not provide a response for this demographic variable (see Figure 2). 98 (79.5%) participants, the majority of the sample, stated that they did not

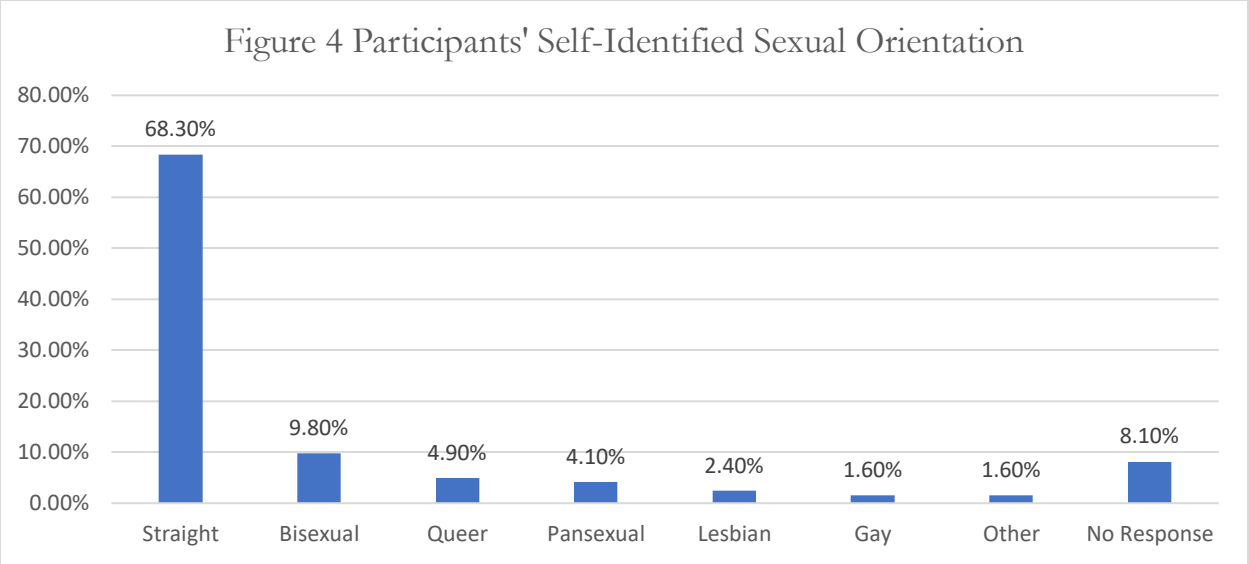
have Hispanic, Latino/a, or Spanish ancestry, while 16 (13.0%) participants said they did. 9 (7.3%) participants did not provide a response to this demographic variable (see Figure 3).

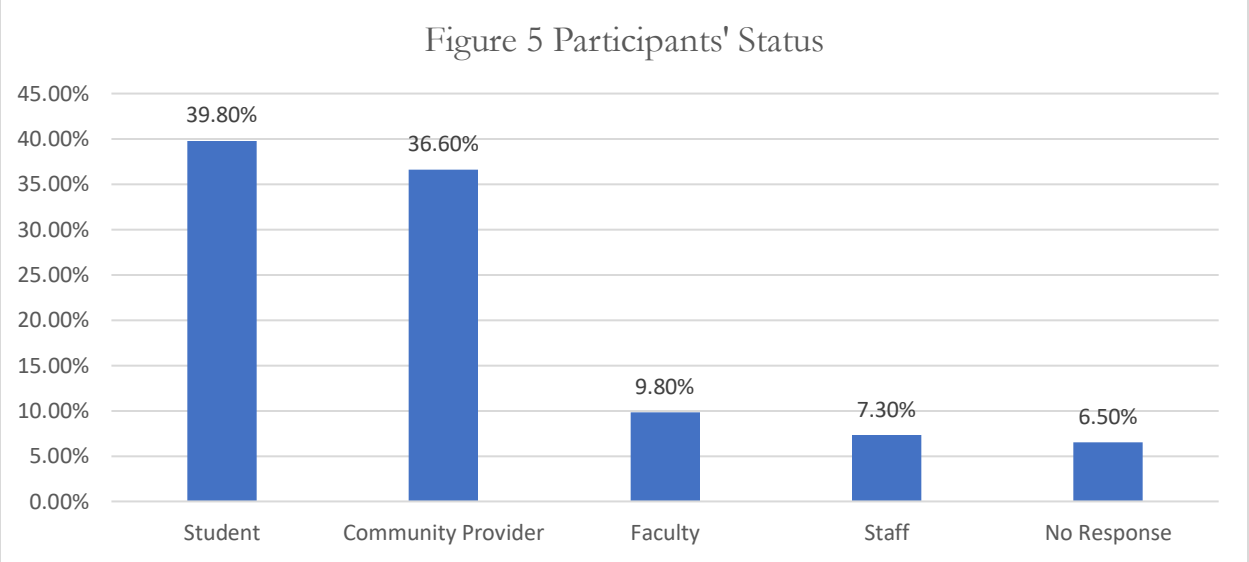




Participants also answered questions about their self-identified sexual orientation. Here, 84 (68.3%) respondents self-identified as straight, 12 (9.8%) as bisexual, six (4.9%) as queer, five (4.1%) as pansexual, three (2.4%) as lesbian, two (1.6%) as gay, and 1 (0.8%) as other. 10 (8.1%) participants declined to provide a response for this demographic variable (see Figure 4).

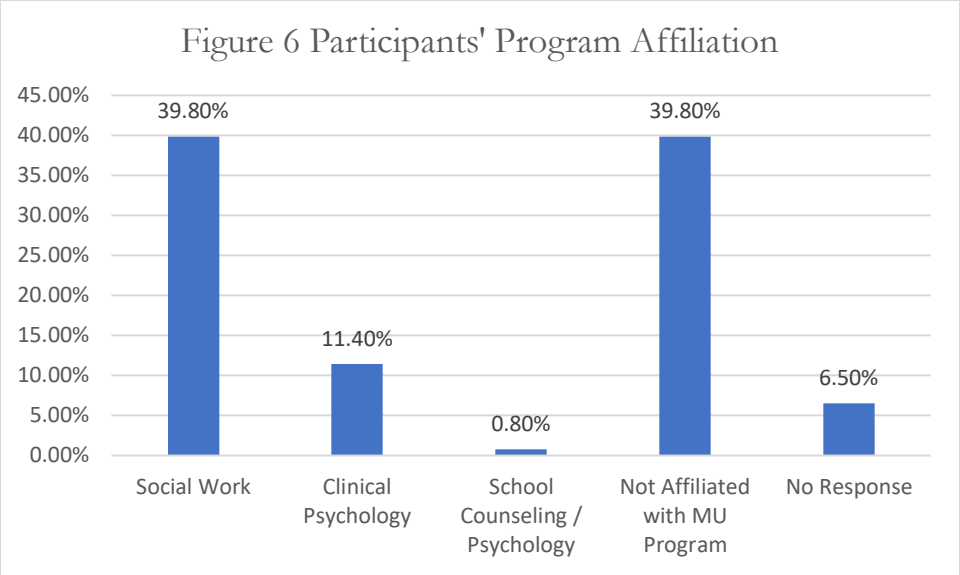
In addition to demographic questions, participants answered questions related to their status and program affiliation (if any) at Millersville University. 49 (39.8%) of the participants said they are students, 45 (36.6%) identified themselves as community providers, 12 (9.8%) identified themselves as faculty, and nine (7.3%) identified as faculty. 8 (6.5%) respondents did not provide a response for this demographic variable (see Figure 5).





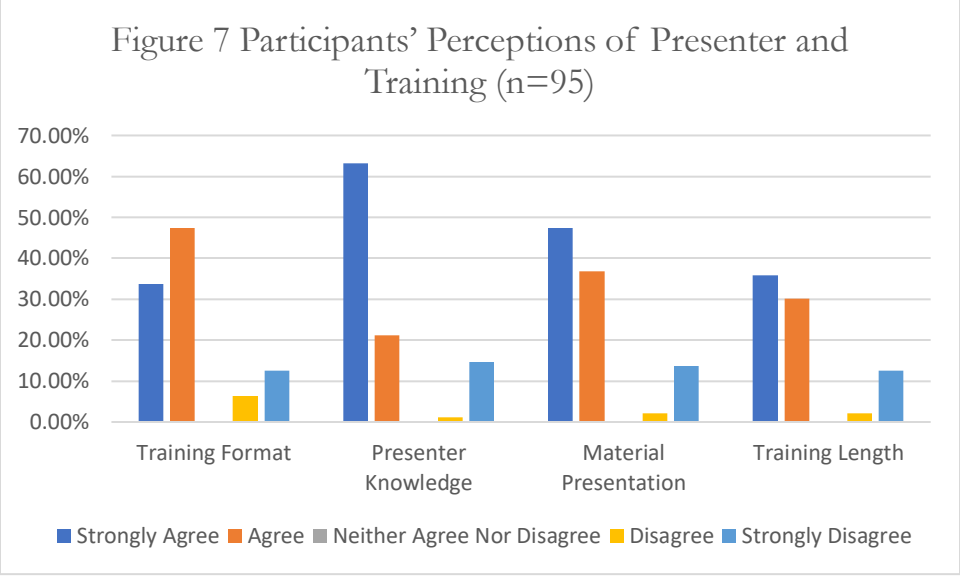
49 (39.8%) respondents did not identify a MU program affiliation, while 10 (8.1%) did not provide a response to this question. 49 (39.8%) participants said they were affiliated with the Social Work department, 14 (11.4%) stated that they were affiliated with the Clinical Psychology program, and one (0.8%) said they were affiliated with the School Counseling/Psychology program (see Figure 6 on the next page).

Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 114 (92.7%) participants provided a response while nine (7.3%) did not do so. Responses ranged from zero to 40 years in the field and the mean was 10.41 years (*SD* = 10.324). The median years worked was 7.



Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included on the post-test survey. Participants were asked to respond to each statement by selecting *strongly disagree*, *disagree*, *agree*, or *strongly agree*. Responses were provided for 95 out of 123 (77.2%) surveys for all four items. Overall, participants were positive about the training. Out of all valid responses, 77 (81.1%) participants strongly agreed or agreed that the format for the training met their needs, while 80 (84.2%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 80 (84.2%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 81 (85.3%) participants strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7).



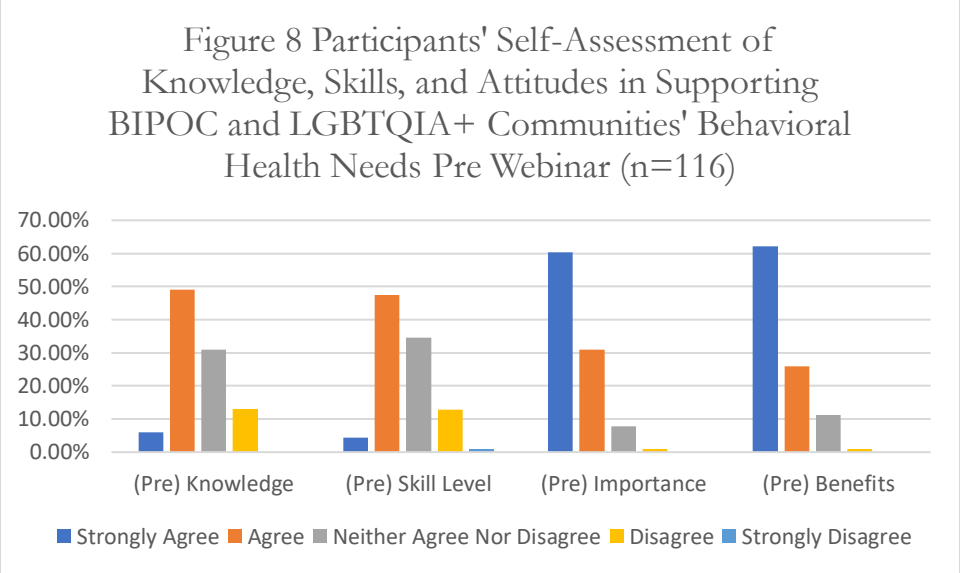
Knowledge, Skills, and Attitudes About Trauma Informed Communities – Quantitative Data Analysis

In addition to questions about demographics and the training, participants were asked, in both the pre- and post-surveys, to select the best response to four statements regarding their knowledge, skills, and attitudes, about trauma informed communities. Using a Likert scale, participants could select *strongly agree* (coded as 1), *agree* (2), *neither agree nor disagree* (3), *disagree* (4) or *strongly disagree* (5). Participants were asked to respond to four statements:

(1) I am confident in my current knowledge about the BIPOC and LGBTQIA+ communities' visibility and representation in the behavioral health workforce.
(2) I am confident in my current skill level in supporting the BIPOC and LGBTQIA+ communities' behavioral health needs.
(3) I believe that understanding and applying best practices in supporting the BIPOC and LGBTQIA+ communities is an important component of practice delivery.
(4) I believe that understanding how best to support the BIPOC and LGBTQIA+ communities can provide positive benefits in the delivery of practice.

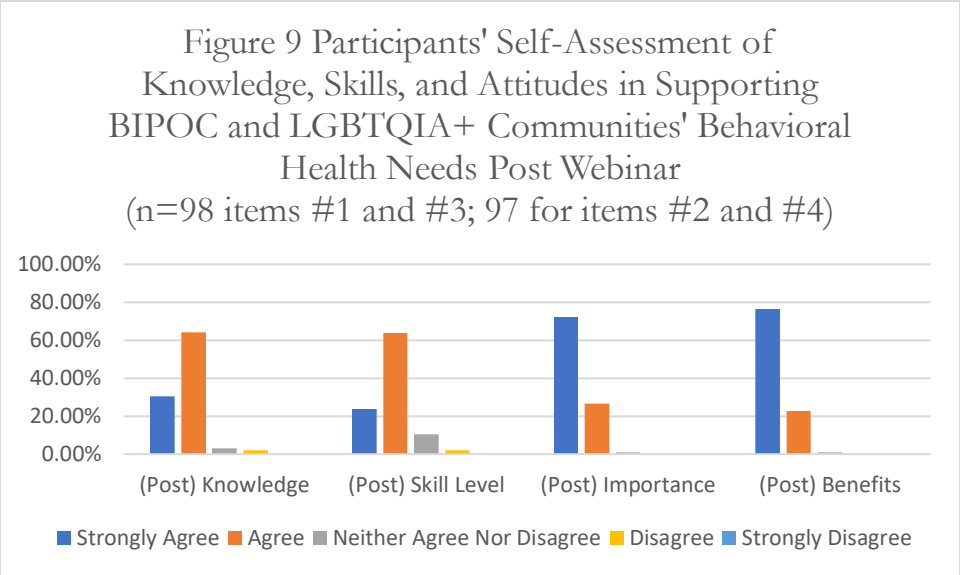
Descriptive Statistics

In the pre-survey, we received 116 valid responses for all four items about the topic. Respondents generally rated their attitudes about supporting the BIPOC and LGBTQIA+ communities' behavioral health needs towards the "strongly agree" and "agree" end of the scale. In contrast, respondents seemed less sure of their knowledge and skills in this area, leaning more towards "neither agree nor disagree." Means were 2.53 for item #1, 2.59 for item #2, 1.49 for item #3, and 1.51 for item #4 (medians were 2 for items #1 and #2, and 1 for items #3 and #4). Responses leaned towards the "positive" end of the scale, as can be seen in Figure 8 (see below).



In the post-survey, we received 98 responses for items #1 and #3, and 97 responses for items #2 and #4. In general, respondents still rated their knowledge, skills, and attitudes about supporting BIPOC and LGBTAIQ+ communities' behavioral health needs towards the "strongly

agree" and "agree" end of the scale, but we see a shift towards the more positive end, particularly for items #1 and #2. Means were 1.77 for item #1, 1.91 for item #2, 1.29 for item #3, and 1.25 for item #4 (medians remained the same – 2 for items #1 and #2, and 1 for items #3 and #4) (see Figure 9).



Inferential Statistics

For this webinar, we matched 91 respondents who completed both the pre- and post-webinar surveys for items #1 and #3, and 90 respondents for items #2 and #4. A two-tailed, t-test for dependent samples was run for each pair of statements for these respondents to determine if their mean changes in responses were statistically significant. Overall, we see statistically significant changes for all four items in a "positive" direction (moving towards the "strongly agree" end of the scale). The magnitudes of the webinar's effects were moderate for all four items, as Cohen's d were 0.776, 0.729, 0.607, and 0.663 respectively (following a guideline of 0.8 as indicating a large effect) (see Table 1 on the next page).

Post-Webinar Qualitative Data Analysis

In the post-survey, we posed two open-ended questions to webinar participants: (1) Which aspects of the training were most beneficial to you? and (2) What do you plan on immediately implementing as a result of attending the training? Below, we provide a summary of participants' feedback and responses. 86 (86.0% of post-webinar participants) participants provided responses to the first question, while 77 (77.0% of post-webinar participants) participants provided responses to the second question.

Most Beneficial Aspects of the Training

As with the previous webinars, participants' responses for this question fell into two broad categories: (1) the format of the webinar; and (2) the content of the webinar. Overall, participants' responses were very positive, with several participants indicating that they found the webinar to be

Table 1 **Dependent Samples T-Test Results for Spring 2023 "BIPOC and LGBTQIA+ Communities' Behavioral Health Needs" Webinar (n=91 for items #1 and #3 and n=90 for items #2 and #4)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about the BIPOC and LGBTQIA+ communities' visibility and representation in the behavioral health workforce.	2.51	1.78	< 0.001
I am confident in my current skill level in supporting the BIPOC and LGBTQIA+ communities' behavioral health needs.	2.60	1.91	< 0.001
I believe that understanding and applying best practices in supporting the BIPOC and LGBTQIA+ communities is an important component of practice delivery.	1.44	1.26	0.007
I believe that understanding how best to support the BIPOC and LGBTQIA+ communities can provide positive benefits in the delivery of practice.	1.42	1.24	0.013

of tremendous benefit overall. It is worth noting that respondents did not provide any negative feedback on this webinar. For instance, one participant responded *"(t)he entirety of the training was very beneficial and educational on current concerns for both communities"* when asked which aspects of the training were most beneficial, while another participant said *"all of it."* A third participant responded they found the entire training to be "*great*, and that they felt *"(t)he presenters were awesome."* A fourth participant commented that they found this webinar to be a reminder, and that "*(i)t is always good to refresh existing knowledge."* A fifth participant concurred that the webinar served as a good refresher, and further elaborated that it *"(i)s always a good reminder, understanding that not everyone has the same experiences. And using kindness and humility and learning from each other as a human being."*

The majority of the comments were also very general, focusing more on broad themes and areas. However, participants identified three key themes to be of major benefit: (1) learning from the presenters' personal experiences and insights; (2) deconstructing privilege, intersectionality, and interconnected; and (3) understanding allyship. Many comments also incorporated at least two of these three key themes, e.g., being moved by the presenters' personal experiences while also learning how best to be an ally. One participant, for instance, said that they found it to be beneficial "*(h)earing the presenters' own experiences; also the conversation about different privileges we have even though we may be oppressed in other areas*," thus combining elements of the first the third theme.

First, many (17; 19.8%) participants found it highly beneficial to listen to the presenters' lived experiences and personal stories. Many of these comments were general and broad, with responses like "*hearing lived experiences*," "*hearing actual examples and first hand accounts*," "*the personal perspectives and insights shared from both presenters*," and "*personal reflection; experiences of speakers*." One participant did elaborate a bit more in detail, saying "*(i)t was refreshing that the presenters were part of marginalized communities"* and that "*(t)hey offered personal perspectives that was a huge benefit to the training*."

Second, 14 (16.3%) participants stated that the part of the training that they found to be most beneficial was unpacking the related, but often confusing, concepts of privilege, intersectionality, and interconnectedness. Many of these comments were brief (e.g., "*better understanding intersectionality*" and "*good to think about self-connectedness*"), with one participant saying that they appreciated "*(d)iscussing how all forms and systems of oppression are interconnected*." One participant provided more insight, saying that they liked how the discussion showed that "*privilege is not cut and dry*" and that they especially liked a quote from Resma Menakem. Another expressed their appreciation of gaining a "*(d)eeper understanding of marginalization and proper language*," while a third participant offered the following as being most beneficial:

> *The intersectionality part of the training and how to training (sic) portrayed that all forms and systems of oppression are interconnected. I always was aware of oppression but I found it interesting how closely indeed are connection (sic).*

Finally, participants (7; 8.1%) said they found the webinar's focus on being an ally to be beneficial. Several provided general and broad comments, e.g., saying that they found *"(h)ow to be mindful or an ally and your role in how to be an ally"*, and *"(t)he discussion on allyship,"* to be most beneficial. Three participants did provide more specific comments. One participant connected the discussion on allyship to the third theme of privilege, intersectionality, and interconnectedness, as well as to self-reflection, saying

> *The most beneficial aspects of the training was learning more about diversity and inclusivity*, *what a true ally is and how I can implement them into my life and looking at my friend groups/my life to analyze where I can be more inclusive and diverse.*

A second participant clarified that it was beneficial for them to go beyond the surface of what it means to be an ally, saying that from this webinar, they got "*a better understanding of how the term ally can be used improperly and ways to show up to support communities that have been marginalized*." A third respondent provided a thoughtful response on allyship, confessing that as a result of this webinar, they now have a clearer and more nuanced understanding of allyship, saying

> *The most beneficial aspects of the training for me was gaining more insight and knowledge into both of these marginalized communities. I have up until this training felt very insecure in my knowledge specifically concerning the LBGTQIA+ community. I also found the information on how to transition from an ally to a co-conspirator very helpful, and to be honest up until this training, I too was only aware of being an ally.*

In terms of the webinar's format, participants singled out one aspect as being particularly beneficial – the incorporation of discussion and opportunities for self-reflection (16; 18.6%). As with the comments on allyship above, the majority of these comments were brief (e.g., "*discussions*", "*personal refection (sic)*" and "*exercises offered during training for personal reflection"*). One participant offered that "*the aspect of learning from each other gave (them) a deeper understanding of the topics*" while another said that they appreciated "*(t)he open discussions and authenticity*." One participant reflected on how the webinar afforded them an opportunity for self-reflection, saying

> *I really enjoyed learning about how my close social influences play a potential role in my biases. In other words, it was beneficial for me to examine if I am surrounding myself with a diverse community.*

Implementation

The participants' responses on what they plan to immediately implement as a result of the telehealth training focused on four main areas: (1) practice and service delivery; (2) discussions with colleagues; (3) examining resources more in-depth; and (4) participating in advocacy.

17 (22.1%) participants commented that they planned to implement what they've learned from the webinar into their practice and service delivery. However, most of the comments here were broad, and respondents did not specify how they would do so. For instance, one participant said that they would implement *"(t)he techniques presented,"* while another said that they plan to apply *"what (they) have learned with (their) LGBTQ and BIPOC students and practice clients."* A third participant said that they "*work with individuals from the LGBTA+ population in counseling sessions and (they) think this information on oppression and barriers for this community will influence how (they) approach these sessions*."

While several of the comments relating to service delivery were broad, some participants did specify how they planned to do so, including, for instance, a respondent who said that they planned to "*take in consideration the clients' body language*." Another said that they planned to continue their work "*keeping in mind the diversity of clients and keeping the dialogue open so they can share if they would like*," while a third participant offered that they plan to "*(c)ontinue to provide ethical services to members of the BIPOC and LGBTQA+ communities*." Even more specifically, one respondent specified that they plan to "*improve (their) diagnostic interview to incorporate such intersectionality and better understand (their) patients' identities*," while another said they planned to implement "*more trauma-informed practices in service delivery*."

Second, 14 (14.3%) webinar participants discussed how they would implement what they've learned from the webinar through discussions and conversations with their colleagues and their supervisees. For instance, one participant said that they planned to "*share these insights with (their) colleagues*," while another said they would "*work to become more informed as I work with my supervisees in order to help them be informed as well*." A third participant said that they plan to "*facilitate conversations with co-workers about how to have a more diverse and accurate representation for the clients (they) serve*," while another said they would bring what they've learned "*back to (their) colleagues."* A fifth participant offered that they "*plan on sharing some information*

with others at the job and talk about this training with supervisor (sic) and consider other (sic) to watch this as it was a great training." Finally, a sixth participant spoke about the insights they've gained from this webinar training, saying

> *Overall, this training has give (sic) me a better understanding of the culturally responsible response to healing and I plan to bring my increased awareness into my work with clients and continue to teach my students the importance of this.*

Third, eight (10.4%) participants indicated that they would immediately utilize the resources provided through the webinar, and also enhance their own learning. This ranged from utilizing a specific resource (e.g., "*I will use the intersectionality wheel of privilege to better understand a diversity of experiences"* and "*I ordered "My Grandmother's Hands" and look forward to learning more about racialized trauma*") to a commitment to learning more (e.g., "*(r)eading some of the recommended books*" and "*continuing to process the information presented*").

Finally, six (7.8%) participants focused on future advocacy efforts. For example, one participant said they planned to do "*advocating*," while another said they planned to "*promote positive language*." Yet a third participant said that they planned to "*increase (their) voice at (their) place of work*." A fourth participant said that as a result of this training, she planned to "*use (her) voice to stand up for the marginalized people (she) work(s) with*."

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training was very positive. Participants provided positive feedback, and appreciated the speakers' incorporation of their personal experiences to facilitate conversation and discussion. We found positive statistically significant changes in all four survey items focusing on attitudes, beliefs, knowledge, and skills in regards to BIPOC and LGBTQIA+ communities and the behavioral health care field. Of note, quite a few participants mentioned that post-webinar, they felt much more confident about their knowledge and ability, which indicates that the training helped resolve their uncertainties.

APPENDIX F
PRIME Survey Analysis

Sample Size

The PRIME program participants completed two surveys: one at the beginning of the 2022-2023 academic year and one at the end. There was a total of 67 surveys completed at the beginning of the year. At the end of the year, 70 surveys were completed. Using the participant's MU number or name, the surveys were then matched. 62 participants completed both the surveys at the beginning and end of the year and were used for the pre- and post-test comparisons.

Demographics

As part of the pre-program process, participants answered a series of questions about their self-identified gender, race, sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, and which program, if any, they were enrolled in at Millersville University. For self-identified gender and race, there were eight missing cases. For self-identified sexual orientation, there were seven missing cases. For Hispanic, Latino/a, or Spanish ancestry, there were six missing cases. Finally, for participant status and program information, there were five missing cases. All percentages presented in the discussion below are valid percentages.

54 (80.6%) women, 10 (14.9%) men, two (3.0%) who identified as "other," and one (1.5%) as binary participants participated in the pre-program survey. 58 (86.6%) of the participants identified as White, three (4.5%) identified African American, five (7.5%) identified as Bi- or Multiracial, and one (1.5%) identified as Asian. The majority of the sample (n = 69, 97.1%) said they did not have Hispanic, Latino/a, or Spanish ancestry, while two (2.7%) participants reported that they did. Participants also answered questions about their self-identified sexual orientation. Of the 68 participants who did respond, 55 (80.9%) identified as heterosexual, two (2.9%) identified as gay or lesbian, five (7.4%) identified as bisexual, four (5.9%) identified as queer, one (1.5%) identified as pansexual, and one (1.5%) identified as "other." (See Table 1 on the next page)

In addition to demographic questions, participants answered questions related to their role and program affiliation at Millersville University. 32 (45.7%) of the participants were students, 13 (18.6%) were faculty, and 25 (35.7%) were community providers. Of the 45 students and faculty, 34 (48.6%) said they were affiliated with the Social Work program, while 11 (15.7%) said they were affiliated with the Clinical Psychology program (See Table 2 on the next page). Finally, participants in the pre-program survey reported a minimum and maximum of 0 and 40 years of experience in the field, with a mean of 13.34 years and a median of 10.00 years (st dev = 11.56).

Table 1 Demographics of Survey Respondents

	Number of Participants	Percent
Self-Identified Gender		
Woman	54	80.6%
Man	10	14.9%
Other	2	3.0%
Non-Binary	1	1.5%
Self-Identified Race		
White	58	86.6%
Bi- or Multiracial	5	6.7%
African American	3	4.5%
Asian	1	1.3%
Participant is of Hispanic, Latino/a, or Spanish ancestry		
Yes	2	2.9%
No	67	97.1%
Self-Identified Sexual Orientation		
Heterosexual	55	80.9%
Bisexual	5	7.4%
Queer	4	5.9%
Gay or Lesbian	2	2.9%
Pansexual	1	1.5%
Other	1	1.5%

Table 2 Participant Role and Program Affiliation

	Number of Participants	Percent
Participant Role		
Student	32	48.6%
Community Provider	25	35.7%
Faculty	13	17.3%
Participant Program		
Social Work	34	48.6%
Clinical Psychology	11	15.7%
Not affiliated with MU program	25	35.7%

Scales Utilized

As part of the survey, participants rated themselves on four scales: the *Interprofessional Socialization and Value Scale-21 (ISVS-21)*, the *California Brief Multicultural Competence Scale (CBMCS)*, the *Confidence in Telehealth KSAs Scale*, and the *Confidence in Coping with Patient Aggression Instrument*. Below, we explain the four scales in more detail, and explain the results of data analysis.

Interprofessional Socialization and Value Scale-21 (ISVS-21)

The Interprofessional Socialization and Value Scale-21 (ISVS-21) is comprised of 21 statements. Participants rated the degree to which they hold or display each of the listed beliefs, behaviors, and attitudes using a 7-point scale. The responses on the scale ranged from "Not at All" (coded as 1) to "To a Very Great Extent" (coded as 7). Participants also had the ability to select "N/A" if the statement did not apply to them (coded as 0). The scoring of this scale is as follows. Each respondent has a pre- and post-test ISVS-21 score, which is obtained by adding up the scores of all 21 survey items and divided by 21 (King et al., 2016). The closer that an individual scores to 7, the more likely they are to self-report positive skills in and attitudes towards interprofessional collaboration.

PRIME participants' pre-test scores on the ISVS-21 ranged from 3.86 to 7.00. At the end of the cohort year, participants' post-test scores on the ISVS-21 ranged from 3.67 to 6.81. On a scale of 1 to 7, we might look at what percentage of participants scored below 3.5 – the midpoint. In both the pre- and post-test surveys, 100% of the respondents scored above the midpoint on the scale, indicating that overall, the PRIME participants felt fairly positive about their skills in and attitudes towards collaborative teamwork.

A paired-samples t-test was conducted to examine changes in the mean scores on the ISVS-21. There was a statistically significant increase in mean ISVS-21 scores from Time 1 (M=5.834, SD=0.79) to Time 2 (M=6.31, SD=0.64), $t(60)$, $p < 0.001$ (two-tailed). The mean increase in ISVS-21 scores was 0.47, with a 95% confidence interval ranging from 0.23 to 0.72. The eta squared statistic (0.20) indicated a large effect size, with a substantial difference in the mean scale scores over time. This means that over the course of the PRIME training for 2022-2023, participants scored stronger on their skills in and attitudes towards interprofessional collaboration. It should be noted that participants already began the program with fairly strong scores. Nonetheless, participants' mean scores increased, demonstrating a positive growth in their attitudes towards and abilities in interprofessional socialization and valuing.

California Brief Multicultural Competent Scale (CBMCS)

The California Brief Multicultural Competence Scale (CBMCS) includes 21 questions asking participants about their abilities to assess vulnerable groups and their awareness of their own attitudes and behaviors. Participants responded to each statement on a 4-point Likert scale from Strongly Agree (4), Agree (3), Disagree (2), or Strongly Disagree (1). The CBMCS also includes four subscales measuring different aspects of cultural competence: (1) multicultural knowledge; (2) awareness of cultural barriers; (3) sensitivity & responsiveness to consumers; and (4) socio-cultural diversities. Each participant's answers, based on the pre-determined four areas of cultural competence, were added to create two scores: one pre-test and one post-test (Behavioral Health Services Quality Improvement 2016). Therefore, each participant had eight scores relating to this

scale: one pre- and one post-test score on each of the four subscales. In addition, paired-samples t-tests were also run for each subscale to determine if there were statistically significant differences in mean scores.

We begin with the subscale of multicultural knowledge – which measures whether practitioners recognize "deficiencies in research conducted on minorities; psychosocial factors to consider when providing services to a culturally diverse consumer population" (Behavioral Health Services Quality Improvement 2016:3) and whether they provide "a culturally competent mental health assessment; diagnosis and understanding; and evaluating wellness, recovery, and resilience (Behavioral Health Services Quality Improvement 2016:3). A score 5-11 indicates that the practitioner is in need of training, while a score of 12-20 indicates that the practitioner is competent in this area. Pre-test, 65.2% of respondents scored as competent, and post-test, this percentage increased to 97.1%. In addition, a paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale, which consisted of items 7, 12, 15, 17, and 19 on the full scale. There was a statistically significant increase in *Multicultural Knowledge* scores from Time 1 (M=13.84, SD=2.35) to Time 2 (M=16.26, SD=2.30), $t(60)$, $p < 0.001$ (two-tailed). The mean increase in *Multicultural Knowledge* scores was 2.43, with a 95% confidence interval ranging from 1.83 to 3.02. The eta squared statistic (0.52) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants felt that they possessed, on average, more multicultural knowledge at the end than at the beginning.

The second subscale is that of sensitivity & responsiveness to consumers – which measures whether practitioners acknowledge and "(understand) … divergent social values; communication styles" (Behavioral Health Services Quality Improvement 2016:3) and whether they have the ability to "understand consumers' experiences of racism, oppression, and discrimination" (Behavioral Health Services Quality Improvement 2016:3). A score of 2-8 indicates that the practitioner is in need of training, while a score of 9-12 indicates that the practitioner is competent in this area. Pre-test, 98.5% of respondents scored as competent, and post-test, this percentage increased to 100.0%. In addition, a paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale, which consisted of items 2, 4, and 9 on the full scale. There was an increase in scores from Time 1 (M=10.34, SD=1.14) to Time 2 (M=10.93, SD=1.06). The mean increase in *Sensitivity & Responsiveness to Consumers* scores was 0.59, with a 95% confidence interval ranging from 0.25 to 0.93. The eta squared statistic (0.17) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants felt that they possessed, on average, more sensitivity and responsiveness to consumers at the end than at the beginning.

Third, we examine the subscale that measures awareness of cultural barriers. This subscale measures whether practitioners have an "awareness of self (cultural self-awareness, worldview, racial/ethnic identity) and awareness of others (oppression, racism, privilege, gender differences, sexual orientation)" (Behavioral Health Services Quality Improvement 2016:3). A score of 6-17 indicates that the practitioner is in need of training, while a score of 18-24 indicates that the practitioner is competent in this area. Pre-test, 93.6% of respondents scored as competent, and post-test, this percentage decreased to 95.6%. In addition, a paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale, which consisted of items 1, 8, 10, 11, 14, and 16 on the full scale. There was an increase in scores from Time 1 (M=20.92, SD=2.26) to Time 2 (M=21.83, SD=2.32). The mean increase in *Awareness of Cultural Barriers* scores was 0.917, with a 95% confidence interval ranging from 0.30 to 1.53. The eta squared statistic (0.13) indicated a moderate effect size. This means that over the course of the PRIME training for 2022-2023,

participants felt that they possessed, on average, more awareness of cultural barriers at the end than at the beginning.

Finally, we turn to the fourth subscale of socio-cultural diversities. This subscale measures the practitioner's "knowledge of socio-cultural groups in which ethnicity may not be the major or immediate focus of professional attention (i.e., age, gender, sexual orientation, social class, physical-mental intactness, and disability status)" (Behavioral Health Services Quality Improvement 2016:3). In addition, this subscale also measures the practitioner's "awareness of bias, oppression and discrimination experienced by members of socio-cultural groups" and "knowledge about best practices and treatment considerations for members of socio-cultural groups" (Behavioral Health Services Quality Improvement 2016:3). A score of 7-19 indicates that the practitioner is in need of training, while a score of 20-28 indicates that the practitioner is competent in this area. Pre-test, 60.3% of respondents scored as competent, and post-test, this percentage increased to 94.1%. In addition, a paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale, which consisted of items 3, 5, 6, 13, 18, 20, and 21 on the full scale. There was a statistically significant increase in scores from Time 1 (M=19.98, SD=3.37) to Time 2 (M=23.31, SD=3.01), $t(60)$, $p < 0.001$ (two-tailed). The mean increase in scores was 3.33, with a 95% confidence interval ranging from 2.49 to 4.17. The eta squared statistic (0.52) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants felt that they possessed, on average, more knowledge of socio-cultural diversities at the end than at the beginning.

Self-Reported Confidence in Telehealth KSAs Scale

The Self-Reported Confidence in Telehealth KSAs scale consists of statements in three areas related to the telehealth competencies of knowledge, skills, and attitudes (van Houwelingen et al. 2019). The knowledge section includes nine statements such as "I have knowledge of how telehealth can be deployed in existing pathways" and "I have knowledge of the limitations of telehealth in providing health care" to examine participants' current knowledge level of telehealth-related issues. The skills section includes 15 statements about participants' ability to use technology such as electronic health records, check IT equipment for functionality, and communicate the benefits of telehealth technologies to patients. The attitudes section includes seven questions examining participants' attitudes toward telehealth technology. It includes items such as "I am open minded about using new innovations in IT," "I have confidence that telehealth technology is not difficult to use," and "I can convey empathy through videoconferencing by facial expression and verbal communication." Participants selected their response based on the extent they agreed/disagreed with each statement: Totally Agree (coded as 5), Agree (4), Neither Agree nor Disagree (3), Disagree (2), or Totally Disagree (1).

We created six scores for each participant based on these subscales: (1) pre-test knowledge score; (2) post-test knowledge score; (3) pre-test skills score; (4) post-test skills score; (5) pre-test attitudes score; (6) post-test attitudes score. Each score was created by totaling all the survey items for each subscale. Thus, knowledge scores run from 9-45, skills scores run from 15-75, and attitudes scores run from 7-35. In all three sub-areas, higher scores indicate higher levels of reported self-confidence among the participants.

Knowledge. First, we examine the telehealth knowledge subscale. Pre-test, 98.5% of respondents scored above the midpoint score of 22.5, while post-test, this percentage increased to 100.0%. A paired-samples t-test was conducted to evaluate the impact of the PRIME training on

this subscale. There was a statistically significant increase in scores from Time 1 (M=34.77, SD=6.07) to Time 2 (M=39.10, SD=4.36), $t(59)$, $p < 0.001$ (two-tailed). The mean increase in scores was 4.33, with a 95% confidence interval ranging from 2.66 to 6.00. The eta squared statistic (0.32) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants reported higher levels of self-confidence in telehealth knowledge at the end than at the beginning.

Skills. Second, we examine the telehealth skills subscale. For both the pre and post-tests, 100.00% of respondents scored above the midpoint score of 37.5. A paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale. There was a statistically significant increase in scores from Time 1 (M=62.82, SD=8.27) to Time 2 (M=66.95, SD=7.10), $t(60)$, $p < 0.001$ (two-tailed). The mean increase in scores was 4.13, with a 95% confidence interval ranging from 2.02 to 6.25. The eta squared statistic (0.21) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants reported higher levels of self-confidence in telehealth skills at the end than at the beginning.

Attitudes. Third, we examine the telehealth attitudes subscale. For both the pre- and post-tests, 100.00% of respondents scored above the midpoint score of 17.5. A paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale. There was a statistically significant increase in scores from Time 1 (M=28.97, SD=4.13) to Time 2 (M=31.59, SD=3.52), $t(60)$, $p < 0.001$ (two-tailed). The mean increase in scores was 2.62, with a 95% confidence interval ranging from 1.48 to 3.77. The eta squared statistic (0.26) indicated a large effect size. This means that over the course of the PRIME training for 2022-2023, participants reported higher levels of self-confidence in telehealth attitudes at the end than at the beginning.

Confidence in Coping with Patient Aggression Instrument

The "Confidence in Coping with Patient Aggression Instrument" is comprised of 10 statements (Thackrey 1987). Participants rated the degree to which they hold or display each of the listed items, using an 11-point scale. The responses on the scale ranged from the negative end (coded as 1) to the positive end (coded as 11). For instance, the scale anchors for the item #1, "(h)ow comfortable are you in working with an aggressive patient?" runs from "very uncomfortable" (coded as 1) to "very comfortable." For item #4, "(h)ow self-assured do you feel in the presence of an aggressive patient?", the scale anchors run from "not very self-assured" (coded as 1) to "very self-assured" (coded as 11). All 10 items in the instrument are summed to create one overall instrument score for the respondents; each respondent will have a pre- and post-test overall instrument score. The closer that an individual scores to 111, the more likely they are to self-report confidence in coping with patient aggression.

PRIME participants' pre-test scores on the instrument ranged from 20 to 109. At the end of the cohort year, participants' post-test scores on the instrument ranged from 21 to 110. On a scale of 11 to 110, we might look at what percentage of participants scored below 60.5 – the midpoint. In the pre-test surveys, 44.6% of the respondents scored above the midpoint on the scale. In the post-test surveys, 68.2% of the respondents scored above the midpoint on the scale, indicating that overall, the PRIME participants gained in confidence about their ability to cope with patient aggression over the program year.

A paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale. There was a statistically significant increase in scores from Time 1 (M=61.15, SD=21.11)

to Time 2 (M=67.17, SD=21.69), $t(53)$, $p=0.031$ (two-tailed). The mean increase in scores was 6.02, with a 95% confidence interval ranging from 0.58 to 11.46. The eta squared statistic (0.09) indicated a moderate effect size. This means that over the course of the PRIME training for 2022-2023, participants reported higher levels of self-confidence in coping with patient aggression at the end than at the beginning. However, it is interesting to note that the average overall instrument scores for both the pre- and post-program surveys are only slightly above the midpoint on the scale. Looking at the descriptive statistics, we also see very large standard deviations, indicating a wide dispersion of scores from the mean. We provide the following table as a summary of the statistical analysis conducted for this report (see Table 3 on the next two pages).

Additional Student Feedback

In the post-test survey, PRIME program participants who are students were asked a series of additional questions, the first being their career plans. Out of 28 students, 12 (42.9%) stated that they intend to pursue employment in a career serving at-risk children, adolescents and/or transitional age youth. Six (21.4%) said they intend to become employed or pursue further training in a medically underserved community, four (14.3%) said they intend to become employed or pursue further training in a primary-care setting, two (7.1%) said they intend to become employed or pursue further training in a rural setting, while one (3.6%) said they intend to become employed or pursue further training toward a career in serving military personnel veterans and their families. Three (10.7%) students did not provide a response to this question.

Second, students were asked whether they offered telehealth services and/or participated in training about how to offer telehealth services in their internship (outside of any PRIME trainings). If so, they were also asked to provide an explanation and an estimated number of hours for their whole internship. Out of 28 students, 11 (39.3%) indicated that telehealth provision and training was not part of their internship. Two (7.1%) said that they received additional training – through BHE-TAC and the Positive Change Conference, but did not provide telehealth services. Two (7.1%) others indicated that they were involved in setting up and participating in meetings, discussions, and phone calls via Zoom, but did not provide actual telehealth services. Five (17.9%) students said they provided minimal telehealth services, ranging from one to five hours. Finally, eight (28.6%) students indicated that they provided extensive telehealth services, ranging from 20 to 100 hours. Most of their responses were general, and several only provided an estimate of the number of hours for which they provided services. Two respondents, however, provided more detailed information:

> *Yes - I run two virtual groups per week (approximately 3 hours total per week). Additionally, I meet with two clients who requested telehealth only services (approximately 4 hours per month). I have also provided telehealth services when clients were unable to make it in person and could receive a hybrid model of treatment*

> *We utilized telehealth services when we had patients who were quarantining due to COVID. So, I had to help them get that set up and assist if needed. I also set patients up for telehealth services post discharge and would assist them in setting up the app and even completing intakes and explaining how to use if needed. Most of our meetings were held virtually so I would also have to attend and set up meetings in this manner. So about 50+ hours.*

Finally, students were asked whether they obtained employment or were currently employed. If they responded positively, they were asked to include the agency name and address, their title, and a brief description of the work they do and the populations they serve. Out of 28 students, six (21.4%) indicated that they had not obtained employment and were not currently employed. One (3.6%) stated they worked at Millersville University, but did not further elaborate. Two (7.1%) said

Table 3 Summary of Statistical Analyses and Results for the 2022-2023 PRIME Survey

Interprofessional Socialization and Valuing Scale-21 (ISVS-21)

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
5.83	6.31	$p < 0.001$	0.20
(0 to 7)			

California Brief Multicultural Competence Scale (CBMCS)

Multicultural Knowledge

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
13.84	16.26	$p < 0.001$	0.52
(5 to 20)			

Sensitivity & Responsiveness to Consumers

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
10.34	10.93	0.001	0.17
(3 to 12)			

Awareness of Cultural Barriers

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
20.92	21.83	0.004	0.13
(6 to 24)			

Socio-Cultural Diversities

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
19.98	23.31	$p < 0.001$	0.52
(7 to 28)			

Self-Confidence in Telehealth KSAs Scale

Knowledge

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
34.74	39.10	$p < 0.001$	0.32
(15 to 75)			

Table 3 Summary of Statistical Analyses and Results for the 2021-2022 PRIME Survey (Continued)

Self-Confidence in Telehealth KSAs Scale

Skills

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
62.82	66.95	$p < 0.001$	0.21
(15 to 75)			

Attitudes

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
28.97	31.59	$p < 0.001$	0.26
(7 to 49)			

Confidence in Coping with Patient Aggression Instrument

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
61.15	67.17	$p=0.031$	0.09
(11 to 110)			

Paired-samples t-tests were conducted on all mean pairs.

The score range for each scale and subscale is notes in parentheses under the pre-test mean.

that their internship placement was a work-based placement. Of the remaining 19 students, five (26.3%) said definitively that their current employment was a continuation of their internship placement. For those who indicated that they are currently employed, the types of agencies at which they worked varied, from health care (e.g., Union Community Care) to schools (e.g., High Road School of York) to addiction (e.g., Blueprints for Addiction Recovery). The populations they served varied as well, from students and families to those dealing with addiction to refugees. It was unclear whether the populations served could be classified as "underserved" since the students did not indicate this clearly.

Overall, these are highly positive results for the PRIME program in its second year. Compared to the results for the first year, the scores were higher, and more pre-post changes were statistically significant. While most of the participants entered the program with a strong background in these areas, it is worth noting the significant and strong impact participating in the PRIME program has had on their competencies. Of note, participants displayed the least amount of confidence in coping with patient aggression.

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APPENDIX G
2022-2023 Team-Based Model Survey Results

Sample

Surveys were distributed to all student participants in the PRIME program for the 2022-2023 academic year. A total of 29 students completed the team-based model surveys. 22 (75.9%) Social Work students completed a pre-survey in December 2022, and a post-survey in April 2023, while 7 (24.1%) Clinical Psychology students completed a pre-survey in March 2023, and a post-survey in May 2023. Participants were asked a series of questions about their self-identified gender, sexual orientation, race, and if they had Hispanic, Latino/a, or Spanish ancestry.

23 (82.1%) participants identified as cisgender women and five (17.9%) identified as cisgender men. 24 (85.7%) participants identified as straight, two (7.1%) identified as bisexual, one (3.6%) identified as queer, and one (3.6%) identified as gay. Participants were also asked about their race and if they had Hispanic, Latino/a, or Spanish ancestry. 24 (85.7%) participants identified as White, three (10.7%) identified as African American, one (3.6%) identified as Asian, and one (3.6%) identified as Bi- or Multiracial. Of the 28 participants, only one (3.6%) said they were of Hispanic, Latino/a, or Spanish ancestry (Dominican and Puerto Rican) (see Table 1 on the next page for a summary).

Qualitative Data Analysis

Pre-test Qualitative Data Analysis

In the pre-test survey, students were asked two open-ended questions: (1) Describe your experience working with team-based models within your internship. What were the significant points of learning for you regarding team-based models? and (2) What questions do you still have about team-based models?

Experiences with Team-Based Model and Significant Points

17 out of the 22 (77.3%) of the Social Work students discussed experiencing team-based models and care at their field placements. Three (13.6%) students provided general comments focusing on what they felt were the significant points of the team-based model without discussing their experience. Finally, two (9.1%) students stated that they did not have the opportunity to participate in a team-based model at their placements (both are counseling and therapy based). For the Clinical Psychology students, one out of seven (14.3%) students said they worked individually and didn't have much opportunity to work in a team-based setting. The other six students, like the majority of the Social Work students, described their experiences with the team-based model in their survey responses. Several students described a team-based model at their placement which brought together staff members from different backgrounds and expertise. Here is some feedback provided by the students:

> *At my current placement, we have a team of nurse practitioners, psychologists, licensed clinical counselors, and doctors who create a cohesive holistic approach to wellness for the student body. (SW)*

Table 1 Demographics of Survey Respondents

	Number of Participants	Percent
Participant Program		
Social Work	22	75.7%
Clinical Psychology	7	24.1%
Self-Identified Gender		
Cisgender Woman	23	82.1%
Cisgender Man	5	17.9%
Self-Identified Race		
White	24	85.7%
African American	3	10.7%
Asian	1	3.6%
Bi- or Multiracial	1	3.6%
Participant is of Hispanic, Latino/a, or Spanish ancestry		
Yes	1	3.6%
No	27	96.4%
Self-Identified Sexual Orientation		
Straight	24	85.7%
Bisexual	2	7.1%
Queer	1	3.6%
Gay	1	2.6%

> *My work-based internship holds a variety of employees with different degrees. The biggest team interaction was the clinicians working with the community-based specialist. The CBS staff mentor youth, transport kids to where they need to go, and support them in many ways. The clinical staff provides therapy. (SW)*

> *Since I am within the school setting, I work mostly with other school staff, including counselors, therapists, psychologists, nurses, principals, and police. (SW)*

> *At the Penn State Health Sleep Research and Treatment Center, there are a variety of providers, including CRNPs, DOs, MDs, and psychologists. Often times, the adult patients that we (the Psychology team) see have also seen one of the medical providers before coming to us. (CP)*

> *I had to learn how to communicate information about patients to the psychiatrist, nurse, and social worker during daily meetings. (CP)*

Both Social Work and Clinical Psychology students conveyed three main significant points of learning with the team-based model. First, participants discussed how the team-based model of care provided immense benefits for the clients. One student, for instance, said that their team-based

model of care "*works great when providing support for students (SW).*" Another student opined that the team-based model used at their internship "*makes it more possible for the client to remain at the center and lead in the process because there is no one "expert" clinician. (SW)*" Yet a third student said that their team "*works closely with (their) patients' medical providers to ensure they receive the best care. (CP)"*

Second, students appreciated the support that they received from their colleagues in a team-based model, and the opportunities they had to brainstorm with each other, learning from each other's disciplinary knowledge and perspectives. For instance, respondents offered the following feedback:

> *My experience working with team-based models during my internship has been very good. I appreciate working with an interdisciplinary team because everyone brings something different to the table. Different approaches work with different clients/populations, so I think the variety in staffing is very important. (SW)*
>
> *I have seen how important it is for the staff to be knowledgeable in their areas of expertise to meet the families' needs. (SW)*
>
> *We use a collaborative approach to distribute the workload, reach out to partnering agencies, and communicate with clients and their families. I also worked collaboratively with the other Social Work intern to bounce ideas off of and problem solve our clients' barriers. (SW)*
>
> *This collaborative approach opens up possibilities for collaborative reflection, create meaning and metaphor. I really enjoy working this way. It offers greater opportunity for support and collaborative interdisciplinary care. I think I would find working alone very strange after this experience. (SW)*
>
> *We are all at various levels of knowledge and collaborate on presented clients and their challenges. This allows us to give feedback on interventions used and treatment plans. (CP)*
>
> *I had to learn how everyone comes from different schools of thought and how these varying perspectives may influence opinions and treatment in the inpatient setting. (CP)*

Finally, students from both disciplines pointed out that a key significant point of learning in team-based models is the importance of communication and being on the same page. One respondent said that it was important for them "*to make sure to have clarification of roles and expectations and practice effective communication when using team-based models (SW).*" Another respondent delved deep into what they learned about the importance of communication in team-based models:

> *Communication between team members is a MUST but doesn't always happen. Excentia has a high volume of clients who receive multiple services, which means frequent check-ins with team members are extremely important, but lack follow-through. Some changes have been made to make these team check-ins more regular. However, each team member needs to see the value of the meetings and attend them. Significant points of learning were communication needs to be direct and clear, especially with so many people coming from such different perspectives. One activity for an individual may be looked at from 3 different lenses – a communications person trying to incorporate this individual to use their communication device during this activity, while behavior support may want to use this activity to focus on what new behaviors arise or triggers the individual, and then an employee assistance person may want to see what sort of job skills could arise, and this is all for ONE*

individual doing ONE activity! Communication must be clear, direct, and honest, with the focus being the best interest of the client. (SW)

A third respondent volunteered:

A major point of learning for me with team-based models was learning how to identify who is on the client's team (as it differs between clients where I am located) and what/when to communicate about the client. (CP)

Additional Questions

The majority of the students did not have any additional questions about team-based models in the pre-survey. 8 (28.6%) students provided specific questions, and we list them below:

(1) *How do you introduce a team-based model if an organization has been using a different model?*
(2) *How many on a team are preferred if there is a preferred number?*
(3) *How to practice effective and professional communication when advocating for a client. Knowing how far can a social worker advocate within their position in a school setting?*
(4) *What are they? Are we expected to be exposed to them at our internship?*
(5) *How to improve communications across large teams and large client pools?*
(6) *What are some ways to create teams and encourage interdisciplinary care across and entire organization (more mezzo level)?*
(7) *How do you ensure the client has power when dealing with multiple health professionals with their care – especially in drug & alcohol treatment? I have noticed clients getting multiple calls per week from the agency, and it seems like they are exhausted by all of the appointments.*
(8) *I guess I would want to know more about where they come up most in an outpatient setting.*

Questions (4) and (8) are broad, and of note, come from students who said that they did not have an opportunity to participate in team-based models at their internship placement. Question (2) deals with the logistics of setting up a team-based model, while questions (1) and (6) focus on how get organizations to adopt the model in the first place. Questions (3) and (5) deal with issue of effective communication within the group itself, while finally, question (7) turns the lens around and asks a very important question: how to ensure that the client is able to maintain a sense of autonomy while dealing with a team of healthcare providers.

Post-test Qualitative Data Analysis

In the post-test survey, students were asked the same two questions that they had been asked in the pre-test survey. All students who had completed the pre-test survey also completed the post-test survey.

Experiences with Team-Based Model and Significant Points

Based on the training, participants were able to recognize how much of their internship experience utilizes team-based models. As with the pre-test survey, the broader theme expressed in participants' responses was how often they are working across various specialties, as well as for the benefit of their clients in mind. Below are students' responses that highlight this perspective.

I am at Reynolds Middle School and sit on the leadership team, as well as the core MTSS team each week. The teams work collaboratively to best support students who have

behavioral and/or academic needs, and to implement school-wide policies. We speak openly and make suggestions. Different team members bring their individual expertise to the group, such as the psychologist or the principal. There's the idea of shared responsibility and different members would be assigned different tasks to reach a shared goal. (SW)

It was very interesting trying to navigate the team-based models at my internship site. We have medical staff, wellness staff, case management, peer services, and psychiatric services in addition to counseling services all at the same site. It was sometimes confusing attempting to determine who was in charge of the client's services, when to contact them, and who to involve during certain services. (CP)

Becoming familiar with the roles that the psychiatrist, nurse coordinator, and social worker play in conjunction with my role as a therapist was the most significant thing. I learned how to collaborate with these various practitioners to best serve the patient and accomplish tasks that would have been out of my scape had I been on my own. (CP)

As with the pre-test surveys, students continued to point out the importance of communication and being on the same page as well. For instance, this student provided the following feedback:

My internship is with Blueprints for Addiction Recovery as a utilization review coordinator. I have been able to work with teams within the facility such as medical staff, psychiatrist, case managers, clinicians, supervisors, and directors. I also have been able to work hand in hand with high risk care managers in connecting external resources directly to clients. This, in and of itself, has been a very hands-on approach to learning how to work in a team-based model through direct client care. I have learned how to connect external care managers with internal clinicians to assist in aiding the clients for their best chances for success post-treatment. The most valuable thing I've learned is the importance of team-based communication and how this is paramount to implementing interventions as well as coordinating client care both during and after treatment. (SW)

Additional Questions

Only two students had a question about team-based models in the post-test surveys. These questions are:

(1) *I wonder how these models work outside of the health care field, perhaps on a macro level such as in policy based settings. (SW)*

(2) *I suppose I am curious about what to do when a member of a team is more experienced and will not listen to a less experienced member of the team's input. For example, a medical professional of 10 years versus an intern. Who else do you involve in order to advocate for the client's needs? (CP)*

Similar to the pre-test, these questions dealt with how to establish team-based models in organizations that might be new to them, and crucially, the dynamics of communication and power in team-based interactions.

Overall, the student participants in this year's PRIME cohort had very positive experiences utilizing team-based models in their internship. They opined that they could see

the value and importance of utilizing team-based models, and that they learned valuable skills in communication and knowledge sharing.

APPENDIX H
EMBEDDING PRIME TOPICS INTO COURSES
FALL 2022 AND SPRING 2023
GOAL #4 OBJECTIVE 2
FIRST REPORT SUBMITTED JANUARY 24, 2023
UPDATED REPORT SUBMITTED TUESDAY JULY 18, 2023

As part of the PRIME grant, Goal #4 Objective 2 focuses on embedding telehealth, cultural competency, and resources for addressing youth violence throughout the curriculum. In the grant, it was proposed that we track the data twice a year – through the number of revised courses, as well as interviews with faculty members. The first set of interviews was conducted in December 2022 and January 2023, and the second set of interviews was conducted in May 2023 and June 2023. Interviews were conducted twice with six faculty members (see Table 1 on the next page) via Zoom, and then transcribed utilizing Otter-ai software. All six faculty members granted permission for the interviews to be recorded. Interviewing the faculty twice a year was an effective methodology. We were able to capture both initial responses, as well as their reflections at a later point in time. We were also able to refer to specific comments and thoughts that faculty members had made earlier, and ask them to reflect on those specifically.

Respondents were asked a set of four very broad questions: (1) which classes they enhanced with PRIME topics, which specific topics they embedded, and how they did so; (2) their experiences and assessments of embedding the PRIME topics; (3) their assessment of how their students experienced the embedding of PRIME topics; and (4) changes and modifications they might make moving forward.

In this report, we focus first on the main findings from the first round of interviews. We then examine faculty members' reflections in the follow-up interviews, and assess shifts and changes. Finally, we provide recommendations on how to better support faculty members in their efforts at embedding PRIME content into their courses.

<u>Key Findings and Themes From Initial Interviews</u>

In initial interviews, faculty felt that their courses lent themselves well to embedding PRIME content – the course topics meshed well with the PRIME topics, and faculty did not find it difficult to incorporate this material. Faculty expressed appreciation for this opportunity to have a new catalyst in improving their courses and their pedagogy. Faculty found that cultural competency was the PRIME topic that they found easiest to embed in their courses, followed by telehealth. These two topics are broadly applicable to all aspects of behavioral health, unlike youth violence, since some of the faculty did not focus on children in their courses. Faculty particularly appreciated having the opportunity to incorporate the topic of cultural competency in more unique ways, e.g., asking the students to rethink cognitive behavioral therapy (commonly seen as the "gold standard") utilizing cultural competency as a framework. Overall, faculty felt that the addition of PRIME topics stimulated excellent discussion within the classroom.

Logistically, faculty thought that it was helpful for the students to have access to the webinar trainings, especially with having the dates and topics available in advance. This way, faculty were able to incorporate the trainings into the syllabus, and encourage students to put the dates on their calendar and to plan on attending the webinars. However, some faculty said that in the end, they were unsure whether and which students attended the webinar training.

Table 1 List of Faculty Members Embedding PRIME Topics in 2022-2023

Name	Department / Courses
Marc Felizzi	Social Work
	SOWK 602: Behavioral Health (Spring 2023)
Heberlein, Andrea	Social Work
	SOWK 630: Advanced Field Practicum I (Fall 2022)
	SOWK 631: Advanced Field Practicum II (Spring 2023)
Kelly Kirk-Wentzel	Psychology
	PSYC 633: Systems of Psychotherapy (Fall 2022)
	PSYC 635: Psychopathology (Fall 2022)
	PSYC 630: Group Therapy (Spring 2023)
	PSYC 637: Theories of Family Dynamics (Spring 2023)
Rachel MacIntyre	Psychology
	PSYC 631: Psychotherapy and Intervention (Fall 2022 and Spring 2023)
	PSYC 636: Cognitive Therapy (Fall 2022)
Karena Rush	Psychology
	PSYC 682: Internship (Spring 2023)
Jessica Weiss-Ford	Social Work
	SOWK 630: Advanced Field Practicum I (Fall 2022)
	SOWK 631: Advanced Field Practicum II (Spring 2023)

In the initial round of interviews, faculty raised minimal concerns and challenges. One faculty member suggested that future trainings focus on more underserved populations, e.g., LGBTQ+ population (which did happen during the Spring 2023 semester), immigrant and migrant populations, military veterans and trauma, and adult trauma. Logistically, another faculty member did express confusion about the expectations for faculty participating in the course enhancement aspect of the PRIME program. They were unsure as to

whether there are specific guidelines as to how much and how to properly embed the PRIME content into their courses, and unsure whether they should explicitly highlight the content connection to the grant.

Key Findings and Themes From the Follow-Up Interviews

In the follow-up interviews conducted, faculty had the opportunity to reflect upon their embedding of PRIME topics into their coursework from the Fall 2022 semester, as well as any modifications they made during the Spring 2023 semester. Overall, faculty remained very positive about their experiences participating in this component of the PRIME grant. Many expressed appreciation for the webinar trainings and how it provided a structure for course material. The value of these webinars is primarily in providing background for the theoretical frameworks. Many faculty pinpointed the fact that the webinar trainings, while helpful in establishing the context and theory, did not focus much on application. For instance, one faculty said,

> *I think where the trainings do a nice job is in emphasizing the importance of these topics and discussions. And I think for a lot of the broader discussions, like theory, or what we know of approaching these sorts of topics, I find that where they're missing a lot is the application-based components. Like – I have found a lot of them to be very informative, but then like, what are actually the steps of engaging in a telehealth session. What does an actual session look like? How do we actually talk about cultural differences in a therapy space? I think we emphasize a lot in these trainings about how important the topic is, but we could probably do a bit more application.*

This faculty member did acknowledge the limitations of a three-hour webinar training, saying that it was a big ask to run through the specifics of how to conduct a telehealth session within this format and time constraint.

Faculty, in general, found it easier – this time around – to incorporate PRIME topics into their courses, and with finding ways to enhance the discussion. For instance, one faculty member said that they were now inviting graduates of the grant and MU to come back and be a guest speaker. She explained,

> *So we had someone who graduated the program come back and say, hey, you know, this is how it's been like. There's this real-life thing of working, like you're told, oh, here's the theory. This is why kids do what they do because they work with kids in residential settings. And then, now, you also have to back down and think about realistic goals and to be present. So there's the soft skills versus the theory and all that. We had someone come in … and we say, okay, you've learned this and that here – how that incorporate with what you're doing in the field, and making a difference in terms of what you're now doing in the field, and making a difference in changing residential or juvenile detention? We also had another person who worked with CHOP come to class. Again, okay, you learned this and with what you're doing now, how does that incorporate with stuff that you're doing now?*

While the webinar trainings provided a solid theoretical context, this faculty invited guest speakers to further help students make the connection between theory and practice.

Occasionally, faculty experienced some difficulty in incorporating PRIME topics into their courses. As mentioned in the first round of interviews, this was often due to the PRIME topics not meshing particularly well with the course topic. However, sometimes, faculty felt some ambivalence about PRIME topics, as evidenced by this faculty's reflections on telehealth,

> *I just got done talking to my supervisee, and he's solely telehealth. You know, how do I diagnose a substance use issue or disorder? Looking at you on a screen, how do I – you know – how do I evaluate your psychosis through a screen? You evaluate a client based on how they're dressed. I mean, if they're in your waiting room, and it's the middle of August, and they're wearing a heavy jacket, and they're obviously disheveled, okay, yeah. On telehealth, you can't do that. They're sitting in their bedroom with a t-shirt on.*

Faculty also brought up a couple of logistical issues. First, while faculty appreciated that they had access to the webinar recordings and slides, they said that it could be difficult to locate the particular email with the webinar link and information. It might be helpful, one faculty member suggested, to have all the webinar recordings stored and easily accessible in one central location.

More importantly, faculty members also felt a little distant in their participation. In the first round of interviews, some faculty members had expressed their confusion about grant expectations and wanted to be sure that they were embedding the PRIME content appropriately. This time around, while faculty felt more confident in their understanding of the grant expectations, they felt somewhat isolated. For instance, a faculty member said,

> *That actually makes me think – you know, I don't even know who the other PRIME faculty are. … I'd like to hear from everybody else, how they're incorporating the PRIME content, because I have no idea who they are. It feels very isolating, kind of as a – I'm just doing what I'm supposed to do, but I don't know who else is doing this. It wouldn't even have to be a meeting. It's sort of like – here's a time to drop in. It would be nice to know who the other faculty are.*

Conclusion

Overall, for this academic year, faculty involved in embedding PRIME topics into their courses had a positive experience. Many of them expressed their appreciation for this opportunity to revise their courses, and the challenges and excitement of updating their pedagogies. They found the webinar trainings to be helpful in providing theoretical context, and were appreciative to have access to the recordings and slides. Faculty did begin to realize that they needed to work on helping the students make connections between the theories and applications. While earlier concerns about grant participation guidelines and expectations were generally addressed, faculty discussed feeling isolated, and were interested in actively participating in a PRIME teaching community, so that they could exchange ideas and discuss how their pedagogies.

APPENDIX I
INTEGRATING EXPERIENTIAL LEARNING EXPERIENCES INTO COURSES
FALL 2022 AND SPRING 2023
GOAL #4 OBJECTIVE 3
FIRST REPORT SUBMITTED JANUARY 24, 2023
UPDATED REPORT SUBMITTED TUESDAY JULY 18, 2023

As part of the PRIME grant, Goal #4 Objective 3 focuses on integrating experiential learning experiences into Social Work, Clinical Psychology, School Psychology, and School Counseling courses. In the grant, it was proposed that we track the data twice a year – through the number of revised courses, as well as interviews with faculty members. The first set of interviews was conducted in December 2022 and January 2023, and the second set of interviews was conducted in May 2023 and June 2023. Interviews were conducted with all faculty members via Zoom – in some cases, twice (see Table 1 on the next page), and then transcribed utilizing Otter-ai software. All faculty members granted permission for the interviews to be recorded. As with embedding PRIME topics into courses, interviewing the faculty twice a year was an effective methodology. We were able to capture both initial responses, as well as their reflections at a later point in time. We were also able to refer to specific comments and thoughts that faculty members had made earlier, and ask them to reflect on those specifically. We were able to interview each faculty member at least once during the 2022-2023 academic year, and in some cases twice (see Table 2 on pg. 3).

Respondents were asked a set of four very broad questions: (1) how they used the Kognito simulations in their classes; (2) their experiences and assessments of using the Kognito simulations; (3) their assessment of how their students experienced the use of Kognito simulations; and (4) changes and modifications they might make moving forward.

In this report, we focus first on the main findings from the first round of interviews. We then examine faculty members' reflections in the follow-up interviews, and assess shifts and changes. Finally, we provide recommendations on how to better support faculty members in their efforts at integrating experiential learning experiences into courses.

<u>Key Findings and Themes From Initial Interviews</u>

In initial interviews, faculty generally had positive feedback on integrating Kognito as a form of experiential learning in their courses. There was some trial and error in the early phases of implementation, with faculty and students working through the most effective ways to incorporate the Kognito simulations. Generally, faculty set up formats where they worked with the students on some part of the simulation together – either on the beginning or the entire exercise. There were both strengths and weaknesses in utilizing this approach.

Faculty expressed that it was helpful for the students to have a structured introduction to the Kognito simulations, and to have guidance throughout the processes. Faculty members also felt that it was effective for them to incorporate conversation and discussion throughout the process of going through the simulations together with the students. It was faculty's impressions that the simulations were effective in helping students make connections between theory and action. They felt that students did find the simulations helpful and less nerve-wrecking, especially since they were often "left alone" in the field. This was a good opportunity for them to experience field work in a less-pressured context, and also helpful for those students who had not had extensive field experience.

While faculty generally reported positive experiences with the Kognito simulations, they reported some difficulties as well. Even though it was a good idea to walk the students through the simulations, providing

Table 1 List of Faculty Members Integrating Experiential Learning Into Courses in 2022-2023

Name	Department / Courses
Heberlein, Andrea	Social Work SOWK 630: Advanced Field Practicum I (Fall 2022) SOWK 631: Advanced Field Practicum II (Spring 2023)
Wanja Ogongi	Social Work SOWK 630: Advanced Field Practicum I (Fall 2022) SOWK 631: Advanced Field Practicum II (Spring 2023)
Karena Rush	Psychology PSYC 682: Internship (Spring 2023)
MK Strohman	Social Work SOWK 630: Advanced Field Practicum I (Fall 2022) SOWK 631: Advanced Field Practicum II (Spring 2023)
Jessica Weiss-Ford	Social Work SOWK 630: Advanced Field Practicum I (Fall 2022) SOWK 631: Advanced Field Practicum II (Spring 2023)

guidance and structure, it was a time-intensive process, which left little time for a comprehensive debriefing and reflective process at the end. The simulation itself did not do a comprehensive job in providing a larger context which, the faculty pointed out, made it difficult for both the students and themselves in trying to properly situate and contextualize the case study and interaction. Some faculty pointed out that the simulations were focused on case management at the micro level, which made it difficult to students focused on meso or macro level social work to make the connections. Finally, one faculty noticed that students were quite fatigued by the time they participated in the Kognito simulations, and posited that it might be a good idea to place the simulation earlier in the semester.

Table 2 Interview Schedule With Faculty Incorporating Experiential Learning Experiences in 2022-2023

	Late Fall 2022	Early Spring 2023	Late Spring 2023
Andrea Heberlein		X	X
Wanja Ogongi		X	
Karena Rush			X
MK Strohman	X		
Jessica Weiss-Ford	X		X

Key Findings and Themes From Follow-Up Interviews

Overall, faculty felt that the Kognito simulations still added to the students' field work experiences. The issues and concerns they expressed are, in some way, inherent in the nature of a simulation. For instance, one faculty explained,

> *I had, as usual, mixed feelings about it. I think my students who were weaker in clinical skills felt that it was a really nice way to practice skills, and students who had already been doing clinical work felt that it was a little restrained in its abilities. … One student described it as like a "Choose Your Own Adventure" book, which I thought was really cool. … They really liked the product value of the simulation questions. So the quality was really high, but at times, it felt sterile or clinical. It doesn't feel realistic at times. So there's "undo" button, which doesn't exist in real life. But the students really appreciated the "undo" button and being able to explore different paths.*

While this faculty member felt that the simulations were of value to students weaker in clinical skills, they thought that it was less so for those who had more field experience. In addition, the issues with the simulations – realism, sterility – are probably inherent in any kind of field work simulation; it is very difficult to produce a realistic and true to life case management simulation.

Another faculty member said that after their first experience using Kognito, they decided to modify some of the ways in which they incorporated in in their course. For one, they worked with another colleague to bring together students in both classes, and have the combined group of students work through the simulation together. This faculty member further explained,

> *That worked incredibly well. I especially appreciated it because they (the other faculty member) were able to bring in their micro level experience with teens, and that is just not my area of expertise. … There was just great participation. And then, if we wanted to dig a little bit deeper into that, you know, we were able to do that because we had an expert in the room. So, I really enjoyed that. I also think that there's benefit. I mean, it was such a small class. I think it's kind of neat to combine classes. You know, many of them know each other and it is a different kind of way to share knowledge. I'm all about shared learning. I thought it might be too long to fit into a 50 minutes class, but it wasn't. It worked out really well. I would love to be able to do that, you know, next academic year, depending on what the logistics are.*

What we're seeing is the continued trial and error that faculty are experimenting with in order to best contextualize the Kognito simulations. Another faculty who chose to work with another colleague mused,

We did end up combining classes for at least the first one to get everyone acclimated. … We also said, you can also get some support from others in case you're running into issues. So we also used peer support this time. … I think I saw a little bit more engagement this time, but again, I think they were fatigued, but I think that's normal.

This faculty member also suggested that perhaps, another value of the simulations was not just to give the students experiential learning opportunities, but also to provide discussion material for the students. In discussing the simulation scenarios with each other, the students learned quite a bit as well.

In the follow-up interviews, we also asked if faculty felt that their students were applying their experiential learning opportunities to their field work. Faculty generally felt that the students were making these connections, but it was difficult to determine how they were specifically doing so. One faculty, in particular, wanted to pinpoint the connection process, and had their students write reflections on their experience with the Kognito simulations. They said,

This year, I had them write a reflection after their Kognito simulations. I gave them questions, like – here are the things I want you to think about in your reflection. Next time, I will tell them they need to answer all the questions because the reflections varied anywhere from a paragraph to someone who wrote a page and a half of really good information. I asked them to consider: what were the benefits of the simulation? What did you like or dislike about the simulation? How can you use the information gained from the simulations in your internship site?

Conclusion

In general, we're seeing modifications and tweaks from faculty in contexualizing experiential learning in their courses. Faculty expressed that they felt like their utilization of the Kognito simulations were improving and yielding better outcomes with each semester. All faculty interviewed acknowledged – in one way or another – that they needed to be intentional and creative in how they supplemented and structured the students' participation in the simulations. Of note, faculty felt that it was useful to partner with their colleagues in helping students work through the Kognito simulations. Like the faculty members who embedded PRIME content in their courses, these faculty members also expressed interest in learning how their colleagues were utilizing the Kognito simulations, and getting a sense of how well they themselves were doing.