PRIME GRANT ASSESSMENT AND DATA (2023-2024)

Executive Summary and Recommendations

In this third 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. We do not have any major recommendations this year as the PRIME grant seems to be going along very well. Below are some key items to keep an eye on as the PRIME grant moves into its fourth and final year.

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.*

- *PRIME Alumni This would probably be a good time to consider whether the team would be interested in tracking the progress of PRIME alumni and if so, what they would be most interested in measuring. The team might consider following up with grant alumni in terms of employment, progress towards licensure, and knowledge and skills still being utilized from their time participating in PRIME.*

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 19 SOWK students in Fall 2023, there was 100% retention rate.
- 15 students identified as female and 4 students identified as male.
- 12 students identified as White, and 7 identified as African American.
- 16 students identified as non-Hispanic, and 3 identified as Hispanic.

Out of 10 PSYC students in Fall 2023, there was 100% retention rate.

- 10 students identified as female and 0 student identified as male.
- 8 students identified as White, 1 student identified as Asian, and 1 student identified as bi-racial/multi-racial.
- 9 students identified as non-Hispanic and 1 student identified as Hispanic.

Was outcome met?

As of the end of the Fall 2023 semester, outcome #1 **has been met**. For the three cohorts spanning 2021-2022, 2022-2023 and 2023-2024, we have a total of 17 students who identify as students of color, and 8 students who identify as Hispanic.

- There are 12 SOWK students who self-identify as persons of color.
- There are 4 SOWK student who self-identify as Hispanic.

- There are 5 PSYC students who self-identify as persons of color.
- There are 4 PSYC students who self-identify as Hispanic.

The plan was 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 made good progress towards increasing total enrollments from underrepresented groups by 15 students by meeting this goal during the third year of the grant (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 2023 / Late May 2024)
(2) Information about groups receiving the presentations (Late December 2023 / Late May 2024)
(3) Number of people present at each presentation (Late December 2023 / Late May 2024)

Outcome:

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

Data:

For outcomes #1 and #3: For Fall 2023,

21 Initial Youtube Video
48 New Youtube Video
25 MSW Informational Session
30 MSW Orientation Session
15 Presentation to Clinical Psychology Students

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For outcomes #1 and #3: For Spring 2024,

12 Initial Youtube Video
36 New Youtube Video
5 PRIME Open House
0 PRIME Open House Video
34 MSW Open House and Information Sessions
60 MSW Orientation Sessions
43 Discussions with Clinical Psychology Students
25 Conference Presentations to Students and School Psychologists by Dr. Rush

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Was Outcome Met?

- The team did not meet its goal of making informational presentations to at least 500 students a year during 2023-2024 (a total of 354 for the year). However, we should note that this is the third year of the grant, and with only one more year left in the grant, the leadership team still managed to reach a large number of students.
- 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 (as of December 2023)

New PRIME Sites	County	Medically Underserved	Mental Health HPSA
ARC Lancaster	Lancaster	No	No
Crispus Attucks Charter School	York	Yes	Yes
Hope Renewed Counseling Services	Berks	No	No
Innersight Wellness	Westmoreland	No	No
PA Leadership Charter School	Chester	No	No
The American Red Cross	York	No	No

New Sites for Clinical Psychology Program (as of December 2023)

New PRIME Sites	County	Medically Underserved	Mental Health HPSA
Paragon Behavioral Health	Lancaster	No	No
Gethsemane Counseling and Coaching	Lancaster	No	No
Innersight Wellness	Westmoreland	No	No
Realistic Behavior & Therapeutic Services, LLC	Berks	No	No

New PRIME Sites	County	Medically Underserved	Mental Health HPSA
Schreiber Center for Pediatric Development	Lancaster	No	No
Tower Behavioral Health (Eating Disorders Unit)	Berks	No	No
Integrative Counseling Services	Dauphin	No	No

Was Outcome Met?

- For the MSW program, as of Spring 2024, there were six new community partners, one of which is in an underserved area and a mental health HPSA.
    - For 2021-2022, there were eight new community partners, one of which is in an underserved area, and one is a mental health HPSA.
    - For 2022-2023, there were six new community partners, one of which is in an underserved area and a mental health HPSA.

- For the Clinical Psychology program, as of Spring 2024, there were seven new community partners, none of which are in an underserved area nor 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.
    - For 2022-2023, there were seven new community partners, one of which is in a medically underserved area, and two of which were mental health HPSAs.

To summarize, as of Spring 2024, the count is as follows (see Table 1 on next page):

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
2023-2024	6	1	1
TOTAL	**20**	**2**	**2**

Clinical Psychology Program

Year	Number of New Sites	Medically Underserved	Mental Health HPSA
2021-2022	9	1	1
2022-2023	7	1	2
2023-2024	7	0	0
TOTAL	**22**	**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 four partners located in medically underserved areas and five partners in mental health HPSAs.

The program will need to add three 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 2023 and Mid/late May 2024)

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:

Outcomes (1) and (2) were already met during the 2022-2023 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

- 58 staff at community partner organizations participated in the Fall 2023 "Treating Trauma with Evidence-Based Practices Via Telehealth" webinar training.
- 78 staff at community partner organizations participated in the Fall 2023 "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities" webinar training.
- 42 staff at community partner organizations participated in the Spring 2024 "Utilizing Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community" webinar training.
- 48 staff at community partner organizations participated in the Spring 2024 "Introduction to Biblio-Poetry Therapy" webinar training.

Was Outcome Met?

Outcomes (1) and (2) were met during the 2022-2023 year.

For outcome #3 – has exceeded goal for 2023-2024 – 226 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 2023 and mid-late April/May 2024)
(2) Interviews with staff at community partners (Mid/late January/February 2024 and mid-late June/July 2024)

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

- 15 MU faculty and/or staff, 59 MU students, and 58 staff at community partner organizations participated in the Fall 2023 "Treating Trauma with Evidence-Based Practices Via Telehealth" webinar training.
- 14 MU faculty and/or staff, 57 MU students, and 77 staff at community partner organizations participated in the Fall 2023 "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities" webinar training.
- 12 MU faculty and/or staff, 69 MU students, and 48 staff at community partner organizations participated in the Spring 2024 "Utilizing Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community" webinar training.
- 14 MU faculty and/or staff, 46 MU students, and 48 staff at community partner organizations participated in the Spring 2024 "Introduction to Biblio-Poetry Therapy" webinar training.

Measure 2

- Assessment of Fall 2023 "Treating Trauma with Evidence-Based Practices Via Telehealth" webinar training (see Appendix B)
- Assessment of Fall 2023 "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities" webinar training (see Appendix C)
- Assessment of Spring 2024 "Utilizing Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community" webinar training (see Appendix D)
- Assessment of Spring 2024 "Introduction to Biblio-Poetry Therapy" 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 2023 training on "Treating Trauma with Evidence-Based Practices Via Telehealth", 16 out of 17 MSW PRIME site partners attended (94.1%) while for Clinical Psychology, 5 out of 9 site partners participated (55.6%).**
>
> **For the Fall 2023 training on "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities," 16 out of 17 MSW PRIME site partners attended (94.1%) while for Clinical Psychology, 5 out of 9 site partners participated (55.6%).**
>
> **For the Spring 2024 training on "Utilizing Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community", 16 out of 17 MSW PRIME site partners attended (94.1%) while for Clinical Psychology, 8 out of 9 site partners participated (88.9%).**
>
> **For the Spring 2024 training on Introduction to Biblio-Poetry Therapy" webinar training, 15 out of 17 MSW PRIME site partners attended (88.2%) while for Clinical Psychology, 8 out of 9 site partners participated (88.9%).**

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 – mostly met

- PRIME participants reported improvements on all four PRIME survey scales, with most of 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 2023 / mid-May 2024)
(2) Interviews with MU faculty (mid-December 2023 / mid-May 2024)

Outcome:

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

Data:

Thus far, two courses have been created (PSYC 587/639: Existential and Humanistic Therapies and SOWK 602: Behavioral Health).

Was Outcome Met?

For outcome #1: ongoing – 2 out of 3 courses has been created in PSYC and SOWK

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 2023 / mid-May 2024)
(2) Interviews with MU faculty (mid-December 2023 / mid-May 2024)

Outcome:

(1) At least 4 revised courses in each program

Data:

For 2023-2024, the following additional courses embedded PRIME content and topics

- SOWK 520: Micro/Mezzo Social Work Practice
- PSYC 638: Cognitive Behavior Therapies

Including the first two years of this grant, this means that as of August 2024, 4 courses in SOWK and 10 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: met – 4 out of 4 courses have been revised in SOWK; more than 4 courses (10 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 2023 / mid-May 2024)
(2) Interviews with MU faculty (mid-December 2023 / mid-May 2024)

Outcome:

(1) At least 2 revised courses in each program

Data:

- See "Integrating Experiential Learning Exercises into Courses 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 2023 AND SPRING 2024

GOAL #3 OBJECTIVE 3(A)

FIRST REPORT SUBMITTED JANUARY 16, 2024

UPDATED REPORT SUBMITTED AUGUST 6, 2024

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 proposed conducting the needs assessment twice a year. For this third year of the grant, we conducted two sets of interviews – once in the Fall 2023 and once in the Spring 2024 semesters.

We conducted interviews with 13 community partners in Fall 2023 and 3 community partners in Spring 2024. Interviews were conducted via Zoom, and detailed notes were taken for all interviews. The interviews were about 30 minutes in length. All respondents 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 2023, November 2023, March 2024, and April 2024. Each community partner was conducted three times in an attempt to schedule an interview. For the Spring 2024 semester, we experienced great difficulty in connecting with community partners. One community partner did not keep their appointment for their scheduled interview, and attempts to reschedule were not successful. Three additional community partners eventually responded, but attempts to schedule an interview were also unsuccessful. Ultimately, we were unable to secure interviews with 10 of the community partners who participated in the PRIME program for this year, leaving us with a response rate of 72.2% (26 out of 36). 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

Table 1 List of Community Partners Participating in the 2023-2024 Needs Assessment

Name	Organization at Which Intern Conducted Placement
Lakeesha M. Bair-Myers	Paragon Behavioral Health
Karen Bramley	Lancaster Behavioral Health Hospital
	Touchstone Foundation
Katie Bupp	ARC Lancaster
Cary Burgos	School District of Lancaster
Amanda Garlen	ProjectHOME
Jacque George	Hope Renewed Counseling Services
Meagan Howell-Brogan	Franklin & Marshall Counseling Services
Brenda Long	Penn Medicine Lancaster General Health
Emily Myers	Tower Behavioral Health
Abigail Naeve	Pennsylvania Counseling Services
Mary O'Hara	Innersight Wellness
Rosalia Provini	PA Leadership Charter School
Lauren Rineer	Loft Community Partnership
Crystal Smulley	Realistic Behavior and Therapeutic Services, LLC
Trynaty Thompson	Laurel Life
Katherine Walsh	The American Red Cross
Jessica Weiss-Ford	PA Immigration Resource Center
Janine York	Advanced Counseling and Testing Solutions

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>

As with last year's community partners, 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. A few respondents provided very specific responses. For instance, one respondent talked about the importance of proficiency in data and spreadsheet management, especially in being able to use Excel competently. Another respondent focused on the importance of basic biological knowledge and how anatomy affects clients' behavioral health. Overall, however, respondents focused on two main skill sets: (1) communication; and (2) organizational and community knowledge.

First, seven respondents discussed the need for interns to possess strong communication skills. For instance, one respondent said,

> *I think the skills of listening and being able to hear an individual and then circle back, and you might have to circle back three times. What different lines can you use?*

A second respondent elaborated on the importance of communication, and specifically discussed the importance of what they called "telephone skills," saying:

> *I also had the interns call families. I had them call the families to just make that connection. Like, "my name is Jane, I am an intern here at the program at your child's school." That way, they could get used to talking to families and talking to families about stuff going on in the home, because that's an important skill, you know?*

In their response, this community partner also referred to the importance of being pro-active, the importance of reaching out to clients and families sooner rather than later, and trying to establish a relationship early.

Three respondents focused their discussion on communication skills in terms of active listening. These respondents argued that those hoping to succeed in the behavioral health care field need to listen carefully and attentively to their clients, and to learn to build a connection. Building a connection through active listening also helps build trust between the provider and the client, which will go a long way. For

instance, two respondents said the following when asked what they think students need to be successful in this field:

> *I think communication and assessment skills are key for any social worker to connect and really build that rapport with families or their clients in order to be effective and intervene in any way. In my work, you can find all the resources you want, but if you're not connected to that family, nothing's going to be effective. So, I think the most important thing is that connection with the families and to feel that you're aligned with them and that you're on their team. … We're looking at active listening, really, you know, sitting with the family and really understanding where they're coming from in every respect. The only way we can do that is by active listening, and reiterating what they're saying to you. You know, you can verbally just repeat whatever they said to you and sometimes it's just enough to create a connection. So anything like active listening, eye contact, general affirmations – to build that connection and understanding with the family and client.*

> *Oh my god – I remember my field placements. And I panicked, like, for a long time, you know, I felt insane. Like, I don't have the script. And this person is looking to me and thinking I know something but actually I don't know anything at all. You know, it's a pretty scary thing to do, scarier than you think. … That's why I feel like the best thing I can do for students is just to keep reminding them that if you can just stay grounded and just pay super close attention to the other person, listen really closely, you are doing something really meaningful. … You make sure the other person feels you are listening. They feel like they can trust you. And they're going to, you know, disclose more.*

The third respondent, in discussing the importance of active listening, focused on a different related issue – that of interns focusing too much on "checking off the items on the list" and not slowing down enough to listen to their clients. They said:

> *Being able to meet people where they're at, and really try to listen to what people are saying. I know it's really important to get all of the tasks completed within their learning contract. But sometimes, it's not about that. It's about just really being able to listen to people and try to have a conversation and just try to understand where they're coming from. There is a lot of pressure to make sure that people are doing it right … but it's just stepping away from that script, and just trying to listen to people, and just being able to appreciate. There's so much diversity, and there's so much challenge in the world, and you know, especially over the last few years, and they don't have to be perfect. They're learning, but they're really juggling a lot of things.*

This was also part of respondents' discussion about the type of approach and attitude that interns need to have, to which we will return later.

Two respondents also focused on the importance of strong communication skills in a successful career in behavioral health care provision. They focused more on the ability to navigate more negative and difficult encounters and interactions with clients, saying:

> *Confrontation – how to confront in, like – I think when people hear confrontation, and I especially think now – they think it looks very nasty, right? They don't know. They think, oh, but if I confront my client, they're going to be mad at me and they're going to disappear. I'm here to tell you – I've challenged my clients, and my way is usually, you know, I come with love. I have something to say and they're like, okay. But it's already been established in my position that I'm not your best friend. Even though it's an informal look to*

our sessions and we might look like two friends talking. That's the thing – you have get your own sense of self in the room. Who am I in the room? How do I deal with countertransference? How did I set up the stage?

The art of delivering bad news is a very important skill to have, you know. There's a good way to do it, and you can do it without, you know, causing harm simultaneously. You know, really soften the blow. Sometimes, we are the bearer of bad news, and sometimes, we're exclusively the bearers of bad news. In hospitals, they often send the social worker in to deliver the bad news. But I think another important skill is calling to deliver good news, so I do this with parents a great deal as well. I like to call them just to celebrate something small because that's good, you know. It also establishes a really good relationship with the family – like, hey, we got a small win today and I'm all about celebrating the small wins. So they really appreciate it, because then now, we have a give-and-take relationship where they will also give me good news. They'll not just call me because something bad happened, you know, because we teach them to pay attention to good things.

Second, four respondents discussed the importance of organizational and community knowledge. Two respondents talked about the importance of knowing the resources available in the community in which you work, and understanding how to utilize these resources to best support your clients. For instance, one respondent said:

They need to generally understand the different interventions and also of different resources, like, what is a clubhouse? What is a drop-in center? And just exposure to these things, I think, would be really helpful.

Another respondent went into more detail about why it's important to be conversant with community resources. Sometimes, issues might not be related to behavioral health, and if a provider can get to the heart of the issue, and then pair up the client with a helpful community resource, everyone benefits.

I was just talking to my interns about a resource binder – you know, I said that's a really good thing to work on as an intern: create a binder of all the resources in the county that you might need, because even if you're working in private practice, you need to know who and where to refer because, you know, we see people when they're in different kinds of environments. So they might have a ton of anxiety but their anxiety could be like, "I don't know if I'm going to be able to pay my bills." So you need to know what resources to contact to help them. Like, this is a practical problem so let's address this as a practical problem, not necessarily as a mental health problem, you know. Care management is over inundated, so if there's something as simple as getting hooked up with a payment plan for your electricity bill, you know, you don't need case management to be able to do that. You could do that on your own, which is empowering in itself for the client.

Two respondents focused on the importance of understanding the organization at which one works. They elucidate clearly the benefits on organizational knowledge, and one respondent even refers to a course she took at MU, pondering whether that course should be a required course.

They need to learn how organizations work, the rules are different in different places, right? Here, we use this standard, which might not be the standard you used at your previous position. And I think students sometimes have a difficult time understanding, okay, this is a different context, this is a different organization.

You need to know agency structures and how agencies are put together, and who reports to who and why? I mean, I know this is part of the Social Work grad school curriculum, but you know, like board of directors, and why is the Board of Directors important? As an employee or as an intern, what are your rights? You know, are you allowed to call off sick? Or you know, like, are you going to get dinged because you missed seven hours of your internship that week? Is your agency going to come down on your because you missed a day of work because you were sick? What's the call-off procedure? What's the COVID procedure? You know, if I wake up with a cold or if I wake up sneezing or coughing, or am COVID positive, what happens? Do I have access to HR as an intern? (I think I took a class on that. Maybe it was an elective with Dr. Walsh, I think – called "Agencies and Organizations" or something. We did some flow charts – it was a supervision course, like how to be a supervisor and how to supervise people. And part of that was understanding how agencies get put together and who reports to whom.)

Approach and Attitude

In addition to concrete skills and knowledge, respondents, when asked what students and interns need in order to succeed in a career in behavioral health care provision, focused on the approach and attitude needed. As discussed earlier, one respondent discussed how someone might be too focused on "checking off the items on the list" when they need to slow down and listen to the client. A second respondent talked about this as well, saying:

I think a big part of it is empathy and compassion. Because, you know, if you don't have that rapport, and you don't show empathy and compassion to the family and the individuals you're working with, you know, it's going to get off on the wrong foot. … As far as individuals and interns fresh out of school, I think sometimes, you're so focused on the technicalities of whatever your specialty is, that you tend to lose that.

Providers, according to this respondent, sometimes are overly focused on "doing the right thing" that they forget to take a step back and focus on listening to the client and understanding where the client is. Thus, providers can often miss getting to the root of the problem, and an opportunity to help the client. The same respondent continued:

I often see this with behavior technicians, like, hey, you know, the family's not showing up on time, maybe threaten them with discharge? Well, no, let's get to the root of why. Let's talk about like – what can we do schedule wise, while still maintaining our program, of course, and boundaries. But what can we do? Maybe we can adjust the schedule so it's the same, you know, five days a week? How can we assist with parents and meetings? If they're not attending, what do we need to do to adjust what we do and understand that they have a lot going on? You know, this isn't the only thing in their life. So that's one of the examples that, you know, I brought up pretty often with my staff.

Including this respondent, this second main theme of looking at the larger picture and trying to meet the clients where they are was echoed by three respondents. In order to succeed in behavioral health care

provision, providers need to be empathetic and have an ability to work with clients where they currently are. For instance, a respondent said:

> *We need to be realistic about what people can do. Everybody who comes here starts with a clean slate. When they come here, they probably already kind of like – failed out of other places for missed appointments, or whatever reason. Other people gave up on them or other people say you can't come back here again. So when they come here, we say you have a fresh clean slate, we're starting over again. And whatever went wrong in the past doesn't count. I think sometimes, that's hard for the interns coming in here and seeing things that, like you know – I had a man who was on the street for like, four years. And somehow, through a lot – we got him into housing, Section 8 housing no less, and he just failed his housing inspection. Now he's on the street and never to have Section 8 housing again if he can't pass the next time – he doesn't seem to know how to clean his apartment. … I'm not done. I have to go to his house to see him. Does he need cleaning supplies? Does he need someone to instruct him or hold his hand a bit? You know, I don't know. But it's that tension of keeping a boundary, but also realizing the person I'm working with might need help for a number of reasons to be successful and trying to find ways to come around them and provide that when we're able.*

A third respondent took this in a different approach. In contemplating the kind of empathy and approach you need to adopt towards clients, this respondent focused on the provider's own lived experiences, and whether they could draw upon difficult times in their lives to better work with their clients. They said:

> *A little life experience kind of goes a long way too. I think that sometimes, if we've gone through some challenges of our own, if, you know, they've had some work experience and some kind of social service, sometimes that's very helpful. Some exposure to not – you know – sometimes, the intern just goes through from their Bachelors to their Master and sometimes they're juggling, trying to work too. That's really helpful if they're working in some kind of social service field, because then they have a feel for what's happening. And I tend to think that sometimes, that helps people be able to see things a little differently.*

The third main approach and attitude discussed by six respondents could be broadly described as one of being willing to adapt and learn. Two respondents focused on the importance of lifelong learning, saying:

> *You need to have an attitude of learning. My current intern has this in spades – that woman loves to learn, oh my goodness. I can't stop her from getting into a workshop and reading that book and listening to this podcase – she is all about learning, which I love, because that's really going to help her grow so rapidly in the field.*

> *I think it's definitely about seeing a lot of enthusiasm – people really have to want to learn, very willing to, you know – I think it's like when you first started a job, you know, you need a lot of direction. What are those opportunities? It's good when the students want to learn – it challenges us because they're asking good questions and the longer they stay, they definitely get a better idea of what the opportunities are. And then, learning takes place.*

One respondent talked about the importance of being flexible and adaptable, saying:

> *I would say, just being flexible. I have a color-coded calendar of how I would like to go about my day But just knowing that crises occur – they come up, you know, we have a lot of students that I just got an email from, saying they want to harm themselves, so just having the flexibility, you know, knowing when we have to shift*

– yes, we might have a meeting right now, but a student need that's more important may come up. And that's what we need.

Somewhat relatedly, another respondent talked about the importance of being able to handle and cope with the intensity of a job in behavioral health care, saying:

You just walk in and you sink or swim. Fortunately, I swam, but like, a lot of people didn't. And I think programs, even in clinical ones, don't always prepare you for the realities behind it. And also, like, how do you have a 53-minute session, and do case management and fill out paperwork they might need for their instance, like just those – like real life, nuances that come with – those were real life things … I am very firm about interns being allowed to do real work and so I think giving more of these opportunities are really helpful for that in real life.

A fifth respondent talked about the importance of being able to accept criticism and feedback from supervisors, saying:

One is an ability to accept, like, in supervision, okay, I'm going to hear what my supervisor's saying to me. I'm going to accept it, and I'm going to put it into practice, rather than getting defensive. You've got to have that willingness to take whatever is said to you by your boss, or whomever, and own it without getting all bent out of shape about it, if that makes sense?

Finally, a sixth respondent took a broader approach, saying that those aspiring to work in the social work field need to be contemplative and think clearly about how their skill sets can best be utilized. They said:

From my perspective, being in a generalist field, I found I had to kind of find where my skills fit and then how to fine-tune them. So, I think going into the social work field, you have a desire to do some sort of work. It's okay that you're not the expert in it all, but then you need to become the expert. So, coming from the generalist background, and having an interest in people and in compassion and evidence-based practice, it was: how can I fine tune these skills to kind of come together? What did I come to the table with? Where can I gain?

What MU Can Do to Bolster Student Success in the Field

Overall, respondents had positive experiences with MU interns, and many had glowing feedback on the work their interns have done. Several also said that they felt MU has been doing a good job preparing students thus far. For the respondents who provided input on this question, their responses fell into two major categories: (1) skills and credentials; and (2) experience and exposure to a wide range of issues and settings.

Respondents argued for more support in skills and credentials, with one respondent urging MU to encourage licensure, along with a class focusing on the DSM. They said:

> *Have a DSM class the first semester of the first year – it should be the first class you think … I think it's really crucial if someone's looking to get their licensure, which, even if they don't want to be a therapist or a clinician, I encourage everybody to get licensure just because it opens up so many more career doors. And you need the DSM for licensure and to take the test. … It's wild for me when I'm hiring – we find really great candidates, but they don't have their license, and so I can't hire them because we can't bill insurance.*

We should note that a second respondent, who also serves as a faculty at MU, noted that they already encourage students to obtain licensure, saying:

> *I advocate zealously – we also offer students a licensure prep course, before they graduate, and incentivize getting a license. I also teach strategy, you know, I acknowledge that I am not a good test taker. I took the Princeton Review in order to sit for the LSATs. And let me tell you what – essentially, our licensure prep class is Princeton Review, for taking a licensure exam. … We offer students the chance to take it for a very low cost, so that they can, and we do it for everyone at least one time in their studies. … It is something I say to all of our students, and they know they're going to hear it. In every one of my D2L classes, I have an entire module and folder with licensure resources. I update it biannually and I put it in all of my courses.*

Four respondents suggested more course work in specific areas, with the first respondent focusing on trauma-informed perspectives. When asked how they thought MU might help better prepare students, they said:

> *Trauma-informed classes are always helpful, like de-escalation. I feel like students always come in really, really nervous about things like risk assessment and suicide risk assessment. And we always kind of go through that – different ways to practice those things and build comfort. But a lot of that comes in the field.*

A second and third respondent said that they felt more clinical courses and electives would be helpful for students, saying:

> *If there could be clinical specific classes, or even for, like, individuals, outside of being a therapist, but individuals who want to be a case manager.*

> *I have heard that people really enjoyed some of the more clinically based electives. I remember doing a case conceptualization, one where we took the different theories, but we really focused on like: how to build the conceptualization based on that theory. … I would do a monthly check in and we would do the theory and practice. And I remember students who work more clinically based really appreciating that. So maybe stuff like that, or if there's any way like – maybe it just has to be another class or to have some – more micro work … or narrative therapy, which people really like. I don't want to dismiss the macro pieces because I think they're so important. But I think, for them, maybe having a class that walks you through sessions might be helpful.*

A fourth respondent focused more specifically on a skill that they felt students needed:

> *You could practice progress note writing. Oh, that's huge. That's huge. Just give someone a whole case – here's Joey so and so, and here's his behavior. Now, diagnose him, give him treatment goals. Pretend you and your partner have a session and then write up a progress note.*

Finally, a fifth respondent emphasized the need for embedding more social emotional learning into the curriculum, saying:

> *My last plug would be to really focus on social emotional learning in your curriculums. It's widespread – if you can teach your students those soft skills, to teach them those skills of self-awareness, regulation; if you can help them point out the social awareness, the problem solving, the skill setting. I would say that's a valuable tool that they're not only going to take into their practice, but their families, and they'll be able to recognize it in their clients and students.*

We should note that this respondent also acknowledged that the university was reading the book "Permission to Feel," and praised this effort.

Turning to experience and exposure to a wide range of issues, three respondents talked about the importance of getting students exposed to what they're likely to experience in the field and a counseling session. We note that these respondents are aware of the use of experiential learning, via Kognito. While they think that this is a helpful addition to the curriculum, they argue for a different kind of experiential learning, saying:

> *Case review – like, seeing clinical tape and just talking about, like, choices clinicians are making. It's just so nice to be able to hear other perspectives and get other points of view on clinical stuff. I think, as a student, that is always great. Like – the more of that, the better.* (After I mentioned Kognito to the respondent, they responded the following way.) *I mean, if you can see tape, I mean, that's the best, right? I mean, that's when you do trainings and stuff. For me, I just learned so much whenever I can see tape.*

> *Maybe the process of practicing a counseling session. Interns often come to me with natural nerves. It's natural to be nervous. But I don't know what to say, right? So just the real basics of: how do you greet a client or a child in the lobby? What do you say when you're walking down the hallway to the therapy room for the first time or the 17th time? How do you start the conversation, just the practicing of what feel like basic stuff? Because a lot of them come to me and they're just – it's the basics that just terrify them. … Like termination – when you're getting to the end of your counseling cycle and the client's ready to be discharged. How do you count down and terminate? How do you involve the client in that process? Whether they're 2 or 22 or 102? Like, how do you do that? … Just the practical nuts and bolts basics, just – they feel like they don't know about sometimes and it makes them more anxious.*

> *Just preparing our students more for the field to having these conversations about boundaries. And I think, in the field practicum class, they do a really good job at bringing up those, I guess, case studies of what we're seeing in the field placement.*

Respondents who had feedback for this question also focused on the internship / field placement experience, as well as the level of students' preparedness and emotional well-being. Three respondents suggested that perhaps, because of the nature of social work, students needed to be required to undergo

therapy and counseling themselves, so that they can enhance their self-awareness. For instance, one respondent said:

> *Just oversharing of personal information. Is it appropriate? Because I was an intern once and that's how I learned but is it appropriate for me to chime in? I feel like you guys at MU do a really good job at just being transparent … but yeah, I've had at least two or three stern conversations. You know, we don't overshare and what I always like to say is, think about when you're in the profession, this can be an ethical issue, it can get you tied up where you lose your license. … I can probably count on one hand the times I've self-disclosed with students to build rapport. I've told interns that maybe you need a therapist yourself to help work through these things before you're getting into the field.*

A second respondent was similarly blunt about this, saying:

> *They (the students) should be required to see a therapist, you know, whether it be three times, six times, throughout the whole course of the program – that might be a good thing. Because it's a safe place where they can kind of talk about the things that they're experiencing, or maybe things that they've experienced that they've never had treated.*

For these respondents, they felt that what you often encounter in social work and clinical behavioral health provision are difficult and challenging. Those who are new to the field might feel overwhelmed, and end up responding to and interacting with their clients in unhealthy ways – hence the need for students to sort out their own "issues" beforehand.

Finally, three respondents also discussed the need for a smoother connection between the classroom and the field. They attributed different reasons for why they think the connection isn't as smooth as it could be at times, and also proposed different solutions. The first respondent focused on the importance of letting students know that social work is not an easy field, and that students need to be primed to expect to face a challenging array of issues and concerns, saying:

> *Making sure that we're vetting the field placements for the students to get the most of their experience – I know our students have to submit a learning contract, but just making sure that as a site supervisor, I'm able to make sure my student is meeting those competencies in my field placement. Just to, once again, make sure that our students are getting the most that they can while they can. … Just make sure our students have what they need, have conversations about what they can run into in the field, being strategic about the conversations during field practicum. Just being more purposeful about it. I say it because I remember as an undergrad, people saying I go into social work because it's easy – so just making sure we're not just filtering students through because I think they're the next ones that are going to be serving our population that's in need. I don't mean it to be rude, but just anyone that's getting into your major – it is students who have a desire and a heart (that we need). Just like people say nursing isn't for everyone, neither is social work. You have to have the heart for it. Because you encounter things that you know the books don't prepare you for.*

Similarly, a second respondent said they felt that students sometimes come into the field less prepared, due to lack of life experience and exposure to a variety of issues, saying:

> *I feel like when a student does the BSW to MSW track and they have advanced standing, I feel like they're missing a large component of the field time that they really need to get. A lot of these students are traditional students and are very young and don't have experience. And I feel like, all those classes that they're able to miss, for lack of a better word, because it covered the basics in the Bachelors program. I feel like when they move on the Masters, they're not ready. … I also feel like it would be good if Millersville could try to make sure that they're having varied experiences. I don't think two years in the same field is necessarily helping them get the exposure they need. Now, I understand that the placements out there are limited … they also need more classes, and a class that focuses and looks at their own mental health and recognizing that they need more self-reflection and they need to look like where they're coming from.*

Note that this respondent also touches on their belief that social workers might be well served to consider undergoing therapy to enhance their self-reflection and mental wellness.

Finally, a third respondent focused more on the logistics of getting students prepared for their field placement, arguing that the onboarding time was too short. They felt that students could be better prepared for their field placement, saying:

> *Just like more exposure and the classes too, you know, just building that bridge between classwork and field, and I know they have that through some of their classes as they're going through the internship, which I think, is this being able to process things. We almost need more time with the learning contract. Maybe students can read a couple of things before they come or just to prepare. Because you know, they're trying to do some training while they're learning about group work and other things. I don't want to give them too much but you know, they need a bit of background. So I've been thinking about that, like – is there some thing that you know, because I usually get approached, you know, several months in advance, like books or some articles or a couple of podcasts or something. … You know, like, here's a couple of things that I'd really like you to try to get familiar with. And again, like, not something too intensive, but you know, just to start thinking about and so maybe something like that.*

<u>How MU Can Better Convey the Importance of Teams-Based Practice</u>

In interviews with respondents, everyone agreed that teams-based practice was now the norm in most settings. Everyone also agreed that it is important that interns and those aspiring to work in behavioral health care learn to work in teams and to value this practice. Respondents' suggestions for how best to convey the importance of teams-based practice largely fell into two broad arguments: (1) the value of teams-based practice for holistic health care; and (2) the value of teams-based practice in supporting the provider and preventing burnout.

Six respondents talked in-depth about the importance of teams-based practice and its value for the client. They emphasized that clients receive better care from teams-based practice, and that providers are able to offer more holistic, whole person, care. For instance, one respondent said:

> *I think it's just better care because you're looking at whole person care. For example, a student that (the intern) has seen before. Um, he has medical concerns that he follows up with primary care. He has prediabetes, so he has a nurse talking with him about diet changes and physical activity changes. He then gets prescribed psychiatric medication by a psychiatric nurse practitioner, and then we come in to navigate all of that – that's a lot to ask of a person. To be taking their medication, to completely change their diet. … Navigating all of these medical treatments and goals, and being that kind of advocate for the patient to make a better team goal that's more patient centered and patient driven so that patient will actually follow through with some of their health care goals. … Students still have in their mind that solo practitioner mindset, so then we find ways to give them that learning experience. We don't call it therapy, we call it follow-ups. We'll have more follow-ups with certain patients … it's more like supportive therapy, or follow-ups … On the one hand, I love exposing students to this because usually, by the end, they're like, I didn't even know this field existed, and this is a really cool way to work as a team. Or they realize that they want to dive deep into therapy and this isn't really for them, but they got this experience and see the benefit of it.*

A second respondent also discussed the school setting in which she conducted teams-based practice, saying:

> *You know, you can't do it alone. It's cliché, but it takes a village. And there are things, for example – something as small as schedule changing – that's not my lane. So I could be working and supporting this student, you know, it's really affecting them. They're not thriving, struggling with classmates, teachers – whatever the case it, and I can continue to support them and work through that. But it's not until the school counselor makes that change in the class, or something as simple as – I have a student whose dad has to get treatments in New York. We don't want him to go through his parent excuses. 10 parent excuses – he could go through them very quickly. So how do we work around that and support him – we needed our homeschool visitor – we had to loop him in because of the attendance piece. But then we also needed our principal because he needed to be able to approve administrative days for the student. So just remembering that as a social worker, yes, you do bring that gray area to the table. But you need other paint brushes to finish the picture. So you know, for example, once again, that one student support needed for attendance, I could have made that call. But it wasn't up to me – I needed to loop in our HSV, our principal, and at the end, we did and we were able to support and advocate for the family, but with everyone else on board.*

A third respondent, who also works in a school setting, similarly emphasized that teams-based practice is really the best type of care for the client, saying:

> *To be able to provide the best care, you need to work on a team of people in schools. Since we work so much with the rest of the school itself, we have to, you know. … We have to work with either the IEP teacher or the SAP team, or we're always working with principals and guidance counselors. If they have a caseworker, then we're working with a caseworker. They might have multiple caseworkers; they might have a drug and alcohol counselor. So we're going to be working with anybody who's in their life, really. So I'm really adamant about having open lines of communication with anybody who's on (the client's) team. I've been in the mindset of – we have to get everybody on board. It takes a village. We always have to work on a team – no matter what. Social workers are just always on teams. Even in private practice, we are just always part of a team.*

A fourth respondent not only discussed the imperative of teams-based practice, but further emphasized that within a team-based practice, social workers are able to provide unique contributions:

> *We're really big on the whole team dynamic here, we huddle every morning. Everyone on the team is supposed to be there from the person at the front, who signed the person in, to the doctor and everyone in between. So it is a setting where an intern can get a lot of great experience. It's broader than our team when we're collaborating with community providers. I just had outreach a few minutes ago from someone at the Vision Corps, who's a case manager for one of our patients. She's working with them around his vision. So you know, we're working and she's part of his care team. I think that's good and I think the social worker really brings something to that process, because we learn so much about interactions with people and team and all of that. I feel like the Social Work voice helps to keep that at the forefront, at least in this setting. … I think, you know, the foundation of valuing different perspectives. Just like that whole person, and environment, all of that is a good starting point for teams.*

In discussing how to help interns understand the importance of team-based practice, three respondents also focused on how this approach is not only valuable for the client, but for the provider themselves. Working as part of a team allows providers to learn from others, and more crucially, also prevent burnout, and thinking that one must handle everything on their own. Below, we see how they understand the value of team-based practice in providing support and preventing burnout:

> *When we're in session with a client, say, for example, when (the intern) was learning empathic responses. I would tell (the intern) – okay, we're going to take turns. I'll make an empathic response, and then you make one. So, involving the team approach in our therapy sessions. And then, there's another therapist who has an office in my same building and we usually lunch together. So (the intern) and (the colleague) are able to confer on other topics and gain more knowledge and experience there as well. … With what we do, you just can't be a solo person out there, you'll burn out. We require consultation and support and guidance. I've been doing this 33 ½ years, and (the intern) and I will still sit together at lunch. And I'll say, all right, think through this with me. Like, that's just invaluable. You have to have that team mentality. … That's an important point to get across to them – if you do this on your own, you will burn out. You need support and help from other people.*

> *We're trying to teach those very things to people from a therapeutic standpoint: we should practice what we preach. I really also love the idea of trauma-informed agencies and really understanding that from that perspective, so recognizing when to help each other and not look at it as a weakness, but rather, hey, you've had a tough caseload or hey, this is happening. So it's like taking it and expanding it out a little more as we go. … It's really about expanding on the idea that how will we just get along, and everybody's going to win in the long run? Unfortunately, we have more than enough clients out there that need support, including ourselves. So we even say, if you need to go get therapy, or you need something, what is it that you need? So yeah, it's just kind of keeping that network and cohesiveness. And hey, we're all on the same team.*

> *Absolutely! There's just so much expertise sitting at a table and experiences that you may not have experienced or come across, so why not? … They may not be the sole person, you know, responsible for helping someone, but they learn that they prevent themselves from burning out – you get help, and you get support, and so you don't burn out as quickly. It just seems so simple, but I'm always surprised that it's taken us this long to think about it this way.*

Finally, we also note that respondents talked about how they integrate the interns into team-based practice, so that they have hands-on experience. Two respondents (see below) talked about the effort they took to make sure that their interns were able to see how successful team-based practice worked:

> *I feel like here, with our setting, we're so lucky. We're so well-integrated with the medical side, so we can collaborate with them. … I remember after one of our first staff meetings, (my intern) was like – I have never been in a meeting like that. She was like – everyone's contributing, everyone was so active and participating, and you guys really collaborate. Yeah, that's sort of our culture. It's so nice for us, right? If we have a student in crisis, if we have a situation, that's really difficult, you know you can always go find a colleague to support you in that and help you figure it out. We do sort of make a lot of collaborative decisions. I'm really glad that (the intern) – she seems very aware of that aspect of things. … Nobody knows all the answers all the time. Things come up and you're like – ah – I think this would be a good way to go forward. I'm not sure – maybe I should pull this person and you know, it's so nice to be able to talk those things through.*

> *Here in the hospital, we do a lot of team-based work, and we do multidisciplinary. First I approach it with (the interns) together as a group. We involve some of the instructors and some of the test supervisors, supporting each other. Right at the beginning, we meet with everyone together so that we can get to know each other. We take our interns right with us when we go to team meetings and facilitate as a group, so our whole approach has to do with teamwork. We also have different departments, which be a little solo, but it makes up the whole of everything. So being able to shadow some of these other departments and then talking about how everyone comes together, and what does that look like? I think, just trying to explain that, and all the pieces, you know, so just really giving that broad experience. When we've done that in the past, we've had really good luck, and it's really helped our interns be able to see the whole picture.*

APPENDIX B

GOAL #3 OBJECTIVE 3(B)

FALL 2023 "Treating Trauma with Evidence-Based Practices Via Telehealth" Webinar Evaluation

Carrie Lee Smith, Katie Shaffer, and Sarah Qundes

Sample Size

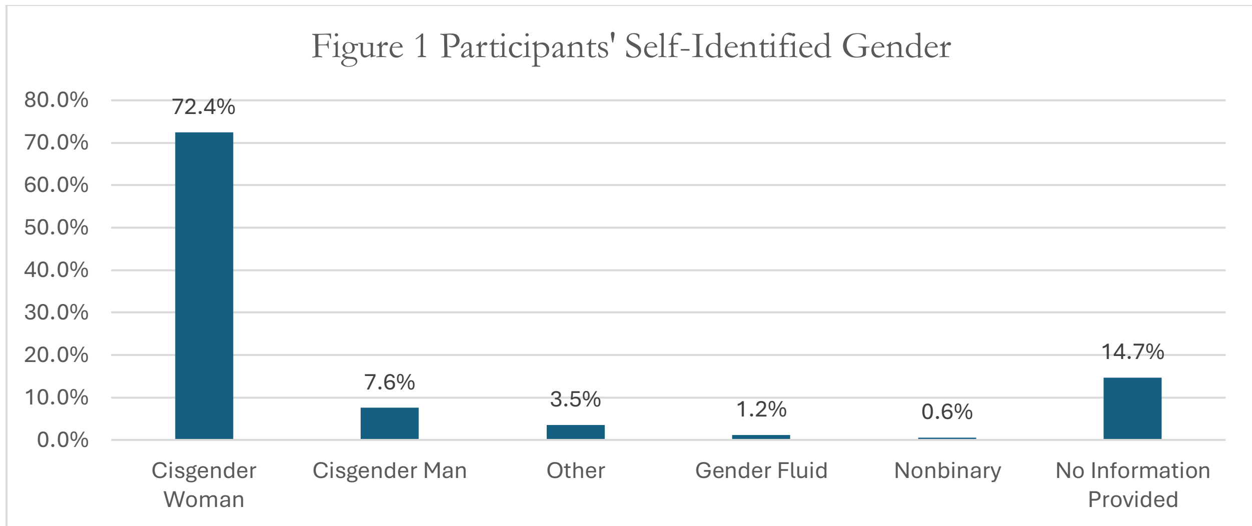
For this webinar training, 50 respondents only filled out the pre-test survey, 20 respondents only filled out the post-test survey, and 100 respondents completed both pre- and post-test surveys. Quite a few respondents completed the same survey twice (or more). For these individuals, we included the first survey they completed, and discarded the second.

Demographics (Based on the Pre-Test Survey)

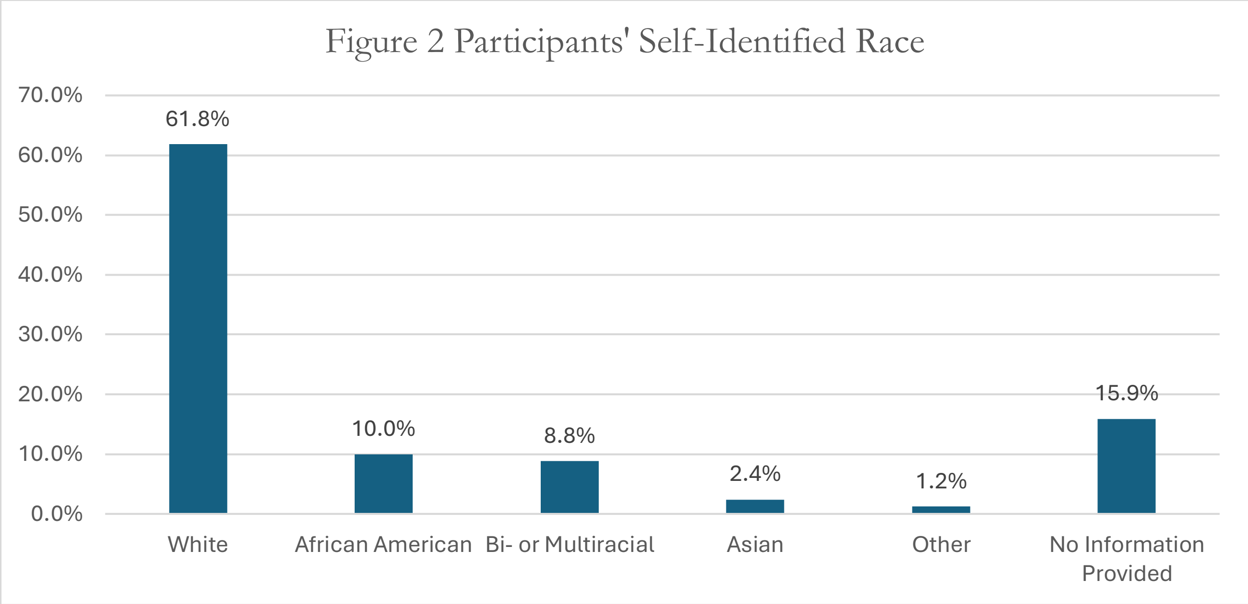
As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, 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 170 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 of these, 69.0% identified an affiliation with the Social Work program. Finally, participants stated a mean 9.89 years of experience in a social work-related or behavioral healthcare field. Due to rounding errors, not all percentages add up to 100%.**

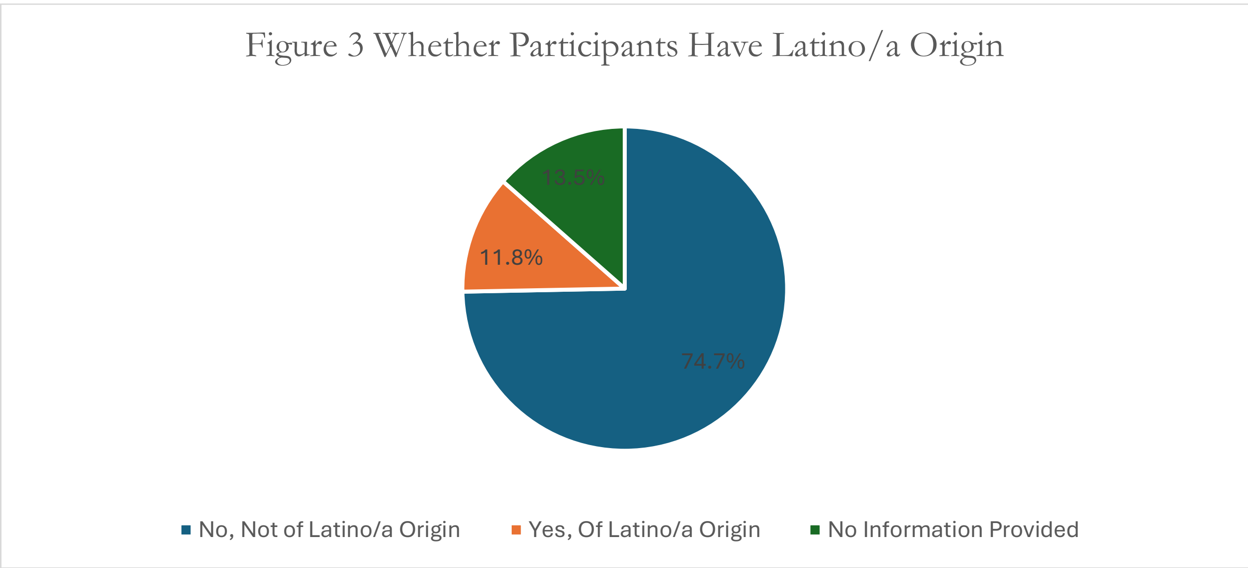
The pre-test sample included 123 (72.4%) respondents who identified as cisgender women, 13 (7.6%) who identified as cisgender men, six (3.5%) as other, two (1.2%) as gender fluid, and one

(1.2%) as nonbinary. 25 (14.7%) respondents did not provide a response for this demographic variable (see Figure 1).

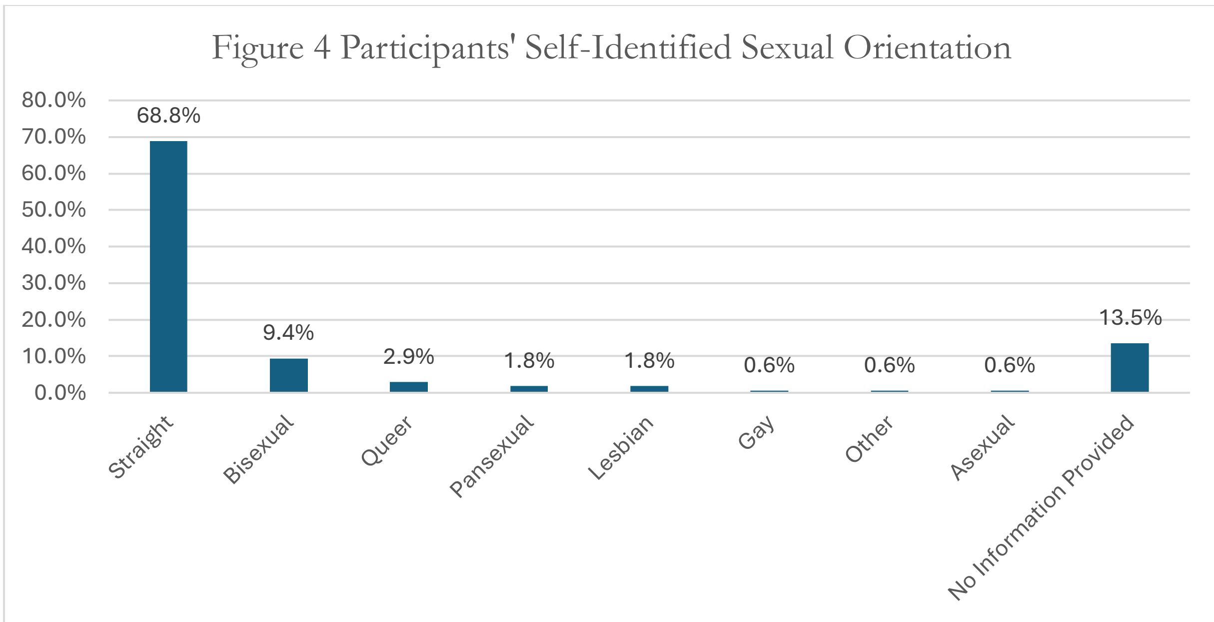


105 (61.8%) webinar participants self-identified as White, 17 (10.0%) self-identified as African American, 15 (8.8%) self-identified as bi- or multicultural, four (2.4%) identified as Asian, and two (1.2%) identified as other. 27 (15.9%) respondents did not provide a response for this demographic variable (see Figure 2). 127 (74.7%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 20 (11.8%) participants said they did. 23 (13.5%) participants did not provide a response to this demographic variable (see Figure 3).

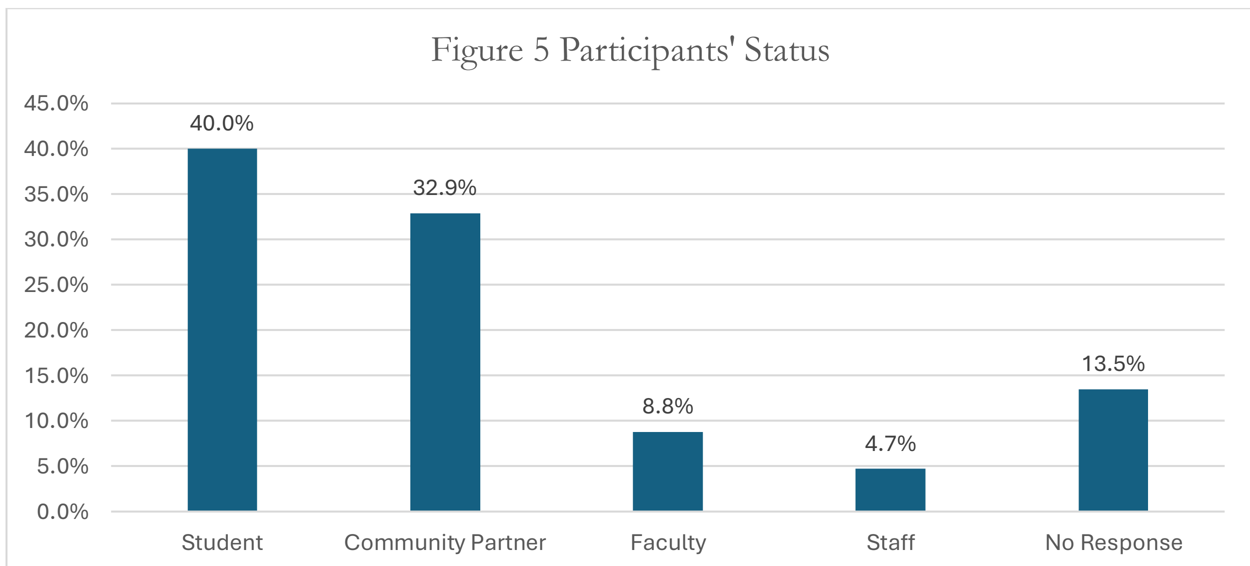




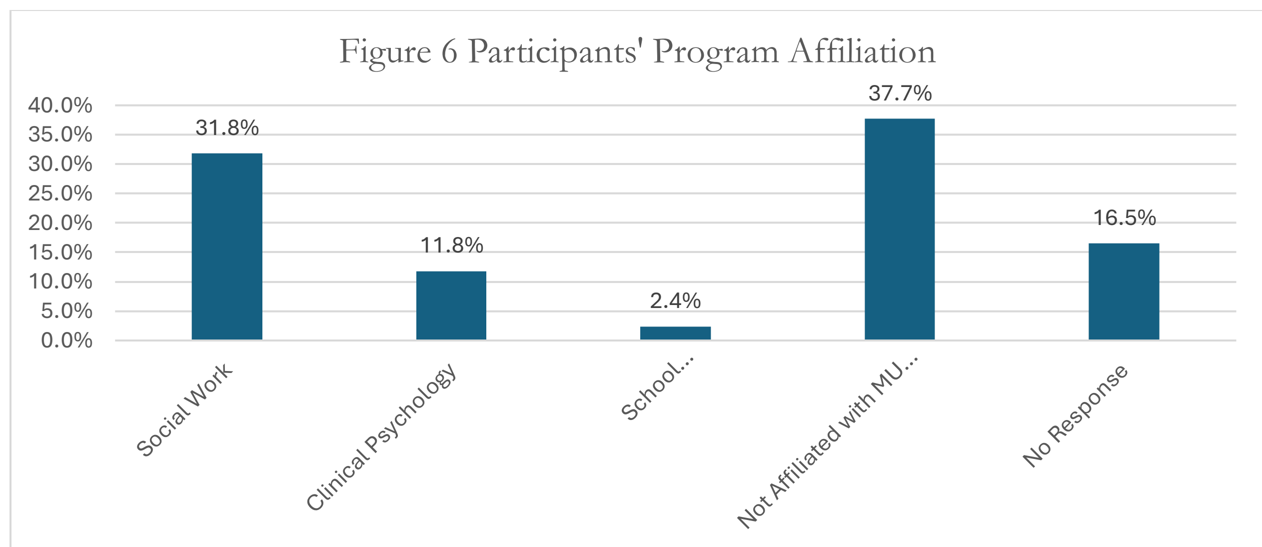
Participants also answered questions about their self-identified sexual orientation. Here, 117 (79.6%) respondents self-identified as straight, 16 (10.9%) as bisexual, three (2.0%) as pansexual, five (3.4%) as queer, one (0.7%) as other, one (0.7%) as gay, three (2.0%) as lesbian, and 1 (0.7%) as asexual. 23 (13.5%) 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. 68 (40.0%) of the participants said they are students, 56 (32.9%) identified themselves as community providers, 15 (8.8%) identified themselves as faculty, and eight (4.7%) identified as staff. 23 (13.5%) respondents did not provide a response for this demographic variable (see Figure 5).



64 (37.7%) did not identify a MU program affiliation (26.5% Community Partner and 11.2% other), while 28 (16.5%) did not provide a response to this question. 54 (31.8%) participants said they were affiliated with the Social Work department, and 20 (11.8%) stated that they were affiliated with the Clinical Psychology program. 4 (2.4%) stated that they were affiliated with the School Counseling/Psychology program (see Figure 6).

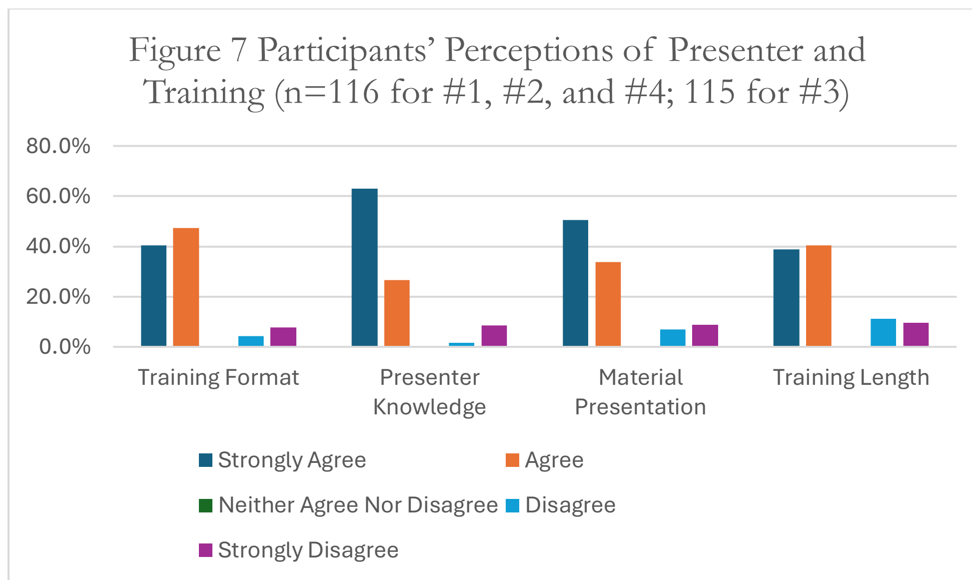


Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 144 (84.7%) participants provided a response while 26 (15.3%) did not do so. Responses ranged from zero to 40.0 years in the field and the mean was 9.9 years (*SD* = 9.9). The median years worked was 7.0.

Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included in 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 116 out of 170 (68.2%) surveys for the first, second, and fourth items. For the third item, responses were provided for 115 out of 170 (67.6%) surveys. Overall, participants were positive about the training. Out of all valid responses,

102 (87.9%) participants strongly agreed or agreed that the format for the training met their needs, while 104 (89.7%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 97 (84.3%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 92 (79.3%) 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 Treating Trauma with Evidence-Based Practices Via Telehealth – 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 conducting cognitive processing therapy in a telehealth context.

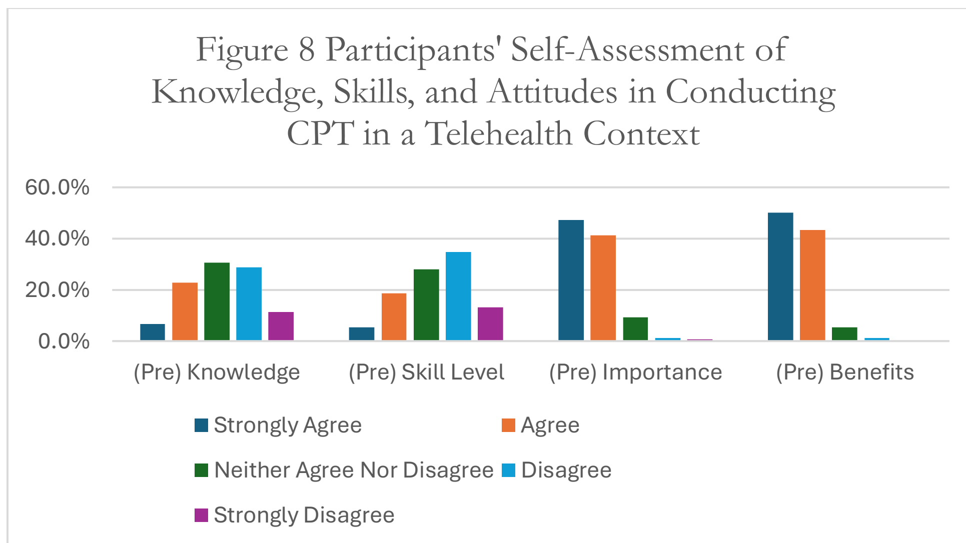
(2) I am confident in my current skill level in conducting cognitive processing therapy in a telehealth context.

(3) I believe that understanding and applying best practices in conducting cognitive processing therapy in a telehealth context is an important component of practice delivery.

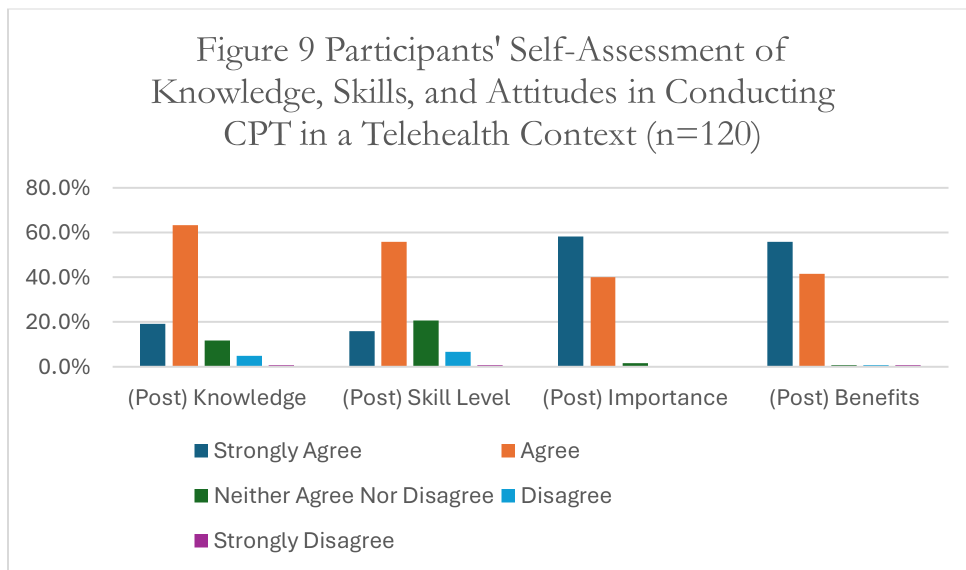
(4) I believe that understanding how to conduct cognitive processing therapy in a telehealth context can provide positive benefits in the delivery of services.

Descriptive Statistics

In the pre-survey, we received 150 valid responses for all four items. Respondents generally rated their attitudes about conducting cognitive processing therapy in a telehealth context 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 3.15 for item #1, 3.32 for item #2, 1.67 for item #3, and 1.58 for item #4 (medians were 3.0 for items #1 and #2, 2.0 for item #3, and 1.5 for #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 120 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 2.05 for item #1, 2.21 for item #2, 1.43 for item #3, and 1.49 for item #4 (medians were 2.0 for items #1 and #2 and 1.0 for items #3 and #4) (see Figure 9 below).



Inferential Statistics

For this webinar, we matched 100 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 100 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 0.975 and 0.995 respectively. The effects were much smaller for items #3 and #4, as Cohen’s d was 0.306 and 0.180 respectively (following a guideline of 0.8 as indicating a large effect) (see Table 1 below).

Table 1 **Dependent Samples T-Test Results for Fall 2023 "Treating Trauma with Evidence-Based Practices Via Telehealth" Webinar (n = 100)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about conducting cognitive processing therapy in a telehealth context.	3.09	2.04	0.002
I am confident in my current skill level in conducting cognitive processing therapy in a telehealth context.	3.26	2.24	< 0.001
I believe that understanding and applying best practices in conducting cognitive processing therapy in a telehealth context is an important component of practice delivery.	1.64	1.42	0.007
I believe that understanding how to conduct cognitive processing therapy in a telehealth context can provide positive benefits in the delivery of practice.	1.62	1.48	0.001

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. 109 (90.8% of post-webinar participants) participants provided responses to both the first and second questions.

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. Of note, participants did not provide any negative comments. There were also no major differences in how students, faculty, and community providers felt about the training.

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 step-by-step introduction to implementing cognitive processing therapy; (2) the emphasis on self-care and healing oneself; and (3) the translation of the model to telehealth. Many comments also incorporated at least two of these three key themes, e.g., being reminded of the importance of self-care while also appreciating the detailed step-by-step introduction.

First, many (55; 50.5%) participants said they very much appreciated the hands-on, practical presentation of the model. In particular, they appreciated all the resources that were shared with them, including the app, and in particular, the assessment worksheets. This was, by far, the most valuable aspect of the training for participants. Many participants provided feedback like *"the breakdown of what it actually is and how it functions*," "*having a breakdown of the process while also having the discussion that allowed for real-life application of the process*," and "*seeing the training manual and learning how to use it in session*" when asked which aspects of the training were most beneficial. It was clear that participants deeply appreciated the presenter working through the manual, and showing them how to implement the model, as evidenced by these comments.

> *I liked that Kim went through the homework sheets so that we could see what they were like to better apply the model.*

A review of CPT and the deep dive into its applications to trauma therapy were great. Dr. Ernest was excellent.

Going over specifics – what to do prior to therapy, looking at the worksheets etc.

I love that she provided concrete tools and examples to do CPT.

Seeing the blank worksheets and examples of them filled out.

The presenter provided great information. Her information and the way she presented was very informative and grabbed my attention, which was good. She showed knowledge and the way she explained it was perfect.

Aspects that were more beneficial to me were specific tasks involved in CPT. For example, learning about how people with trauma can overaccommodate. For instance, by saying "No men can be trusted" after one is cheated on. Or, how a clinician is to probe problematic statements, analyzing implications and consequences. I appreciated going through the specifics about what CPT is and how a social worker is to practice this type of therapy.

The walk through and showing of the actual documents used to conduct CPT.

I enjoyed her examples and her ability to connect with the audience. Her authenticity and ability to explain was beneficial.

Going through the manual step by step to understand what a session would look like realistically using CPT.

I liked how the presenter kept things to the point and also referenced a textbook throughout that guides CPT.

I enjoyed that the training was very much practical. The training gave actual examples, experiences, pros, and cons of telehealth.

Learning more about CPT. It was helpful to see the worksheets and progression on the therapy.

Second, some participants (8; 7.3%) said they found the presenter's focus on self-care and personal healing to be beneficial. Two participants provided general and broad comments, e.g., saying that they found *"the importance of self-care"*, and "*the benefit of your own personal therapy and the need for self-care*" to be most beneficial. Other participants provided more specific comments, including the following:

I appreciated the references to the 'Wounded Healer' and ways for Social Workers/Clinicians to stay well to best serve clients.

I appreciated that the counselor focused on self-care and burnout at the beginning of the training.

Concept of "pretherapy" before starting in to the "heavier" work.

Reminders about how important self-care & doing our own work is, always need to hear it.

I very much liked that she spoke of self-care prior to doing trauma work with clients. I also appreciate the discussion of telehealth adaptations for CPT.

Finally, six (5.5%) participants stated that the part of the training that they found to be most beneficial was the focus on how cognitive processing therapy could be adapted to the telehealth context. We saw an example of this from the prior theme – where a participant expressed appreciation for both the self-care and telehealth adaptations foci. The other four participants also stated their appreciation for the presenter's ability to explain how best to adapt this model for the telehealth context. When asked what they found most beneficial about this training, the remaining four participants said:

Learning about the theories and ways to implement in a non-face-to-face medium

I appreciated that Dr. Kim provided an overview of CPT and provided tips on how to effectively utilize CPT both in-person and via telehealth.

The adaptations for telehealth CPT therapy were beneficial. Explaining how to utilize the CPT manual and having it open during telehealth sessions seemed more feasible. The other adaptations with utilizing the white board feature and recording sessions for supervision were beneficial.

Specific ways to utilize the scripted aspects of it in telehealth sessions

I enjoyed that the training was very much practical. The training gave actual examples, experiences, pros, and cons of telehealth.

As with a prior finding, participants appreciated the practical nature of the presenter's discussion of how to adapt the model to telehealth. Participants found specific tips and hints on implementation to be beneficial. This is, perhaps, the overall major

feedback for this webinar: participants overwhelmingly appreciated the practical, hands-on, step-by-step presentation of the model and how to implement it.

Implementation

The participants' responses on what they plan to immediately implement as a result of the telehealth training focused on three main areas: (1) learning more about CPT and conducting research; (2) incorporating CPT into interactions with clients; and (3) learning more about trauma-informed care.

42 (38.5%) participants commented that they planned to continue learning more about CPT and also looking into additional resources. For instance, one participant said that they would do *"more research of CPT,"* while another said that she wants to *"research more into the concept of pre-therapy."* A third participant said that they plan to *"(be) trained on CPT and becom(e) comfortable with it*," while a fourth said they planned to "*rea(d) more about this model.*" Almost all the participants who planned continuing edition also highlighted their plans to get a copy of the manuals, review the worksheets, or look further into the app. Overall, participants' comments on continuing education were brief and to the point, e.g., *"I plan to buy the book and study it," "getting the manual," and "buying the book to study more!"*

Second, 21 (19.3%) participants indicated that they would incorporate some of what they've learned from this webinar in their sessions with clients. Several of these comments were broad and did not provide specific information. For instance, one participant said they planned to *"(try) some of the CBT interventions,"* while another said they looked forward to *"discovering techniques to implement in session."* A third participant said they planned to *"(implement) skills in current volunteer client sessions,"* while a fourth said they will conduct *"CPT with clients."* These participants were generally excited

about what they had learned, and demonstrated interest in learning more, as they could see how CPT might be a useful model for their clients.

Some participants provided more in-depth information on specific interventions that they plan to implement. Two participants singled out the app (*"The app! I am very excited to share this option with telehealth clients."*), while two other participants said they planned to utilize *"the questioning"* and *"practicing having the conversations."* Three participants said they planned to implement socratic questioning, and seemed excited about its possibilities:

> *Continue to utilize socratic questioning to navigate client experiences when doing community work*
>
> *Socratic questioning is an excellent tool. I see myself implementing this to many of my current clients.*
>
> *Socratic questioning … It feels a lot like narrative therapy but in a different way of getting the information to restructure the next chapter and thoughts within.*

Third, seven (6.4%) participants said that the webinar training had encouraged them to be more thoughtful about their approach to trauma-informed care. Two respondents said that this training made them *"(become) more aware of traumatic experiences and their impact,"* and *"(they) would use CPT with clients with trauma if they were a good fit for the therapy."* Two respondents provided more in-depth responses:

> *I want to try some of the CPT techniques with some of my older elementary students who have experienced significant trauma that has affected them. While I don't work directly with veterans or individuals with PTSD who can best complete this form of therapy, it can help with guiding processing of trauma events and triggers.*
>
> *I work directly under a BCBA with students identified as emotional disturbance, and a lot of what we implement for de-escalation is trauma informed, and aligns with what was shared during the training.*

One final observation from the qualitative survey comments: four (3.7%) participants discussed how the webinar training had made them more thoughtful about how

they approach the provider-client relationship, and behavioral health care, in general. More specifically, they also connected their discussion back to their own sense of self and burnout. When asked what they planned to implement immediately from the training, these participants stated:

> *Addressing my own stuck points and preparing to buy the manual – I definitely see myself learning and practicing the CPT model.*
>
> *One thing that stuck out to me was when Kim said to lean into a model when we are feeling stuck to help reduce burnout, so I want to experiment with that to see how that benefits my work with clients.*
>
> *She emphasized the idea of mastering one model and then learning others. I want to foster that into my profession.*
>
> *The importance of safety, trust, intimacy, power control, and esteem when working with clients. Working on imposter syndrome – "when in doubt, don't use yourself."*

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training was very positive. Participants provided positive feedback, and appreciated the presenter's concrete and step-by-step approach to discussing cognitive processing therapy. We found positive statistically significant changes in all four survey items focusing on attitudes, beliefs, knowledge, and skills in regards to CPT. Almost all the participants who provided comments and feedback on the post-survey indicated an interest and desire to continue to learn about this model, and how it can be used in the provision of behavioral health care.

APPENDIX C

GOAL #3 OBJECTIVE 3(B)

Fall 2023 "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities" Webinar Evaluation

Carrie Lee Smith, Katie Shaffer, and Taryn Nardi

Sample Size

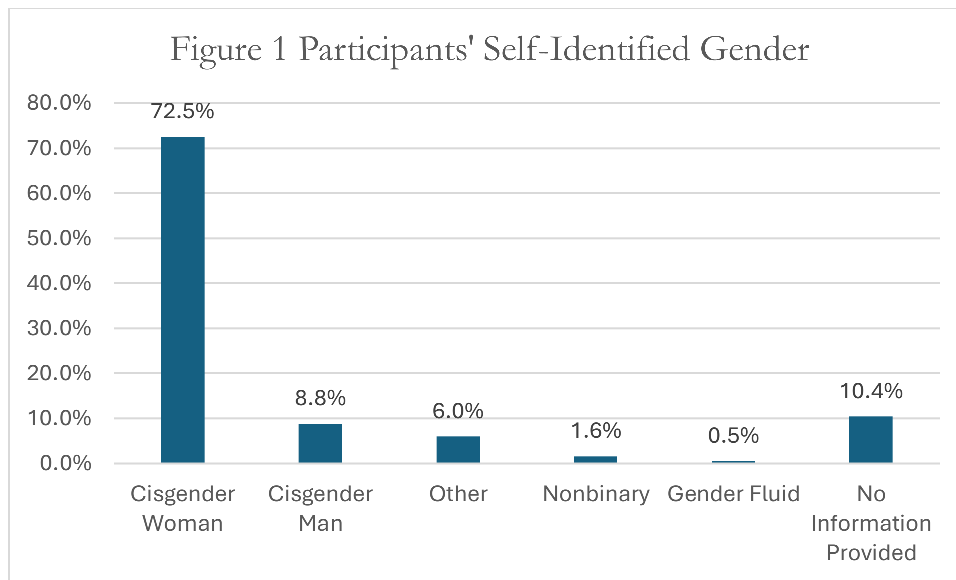
For this webinar training, 60 respondents only filled out the pre-test survey, 14 respondents only filled out the post-test survey, and 108 respondents completed both pre- and post-test surveys. Quite a few respondents completed the same survey twice (or more). For these individuals, we included the 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 182 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 41.3% of valid participants identified an affiliation with the Social Work program. Finally, participants stated a mean 10.71 years of experience in a social work-related or behavioral healthcare field.**

The pre-test sample included 132 (72.5%) respondents who identified as cisgender women, 16 (8.8%) who identified as cisgender men, 11 (6.0%) as other, and three (1.6%) as nonbinary, and

one (0.5%) participant who identified as gender fluid. 19 (10.4%) respondents did not provide a response for this demographic variable (see Figure 1).



118 (64.8%) webinar participants self-identified as White, 24 (13.2%) self-identified as African American, 11 (6.0%) self-identified as bi- or multicultural, seven (3.8%) identified as other, and four (2.2%) identified as Asian. 18 (9.9%) respondents did not provide a response for this demographic variable (see Figure 2). 143 (78.6%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 21 (11.5%) participants said they did. 18 (9.9%) participants did not provide a response to this demographic variable (see Figure 3).

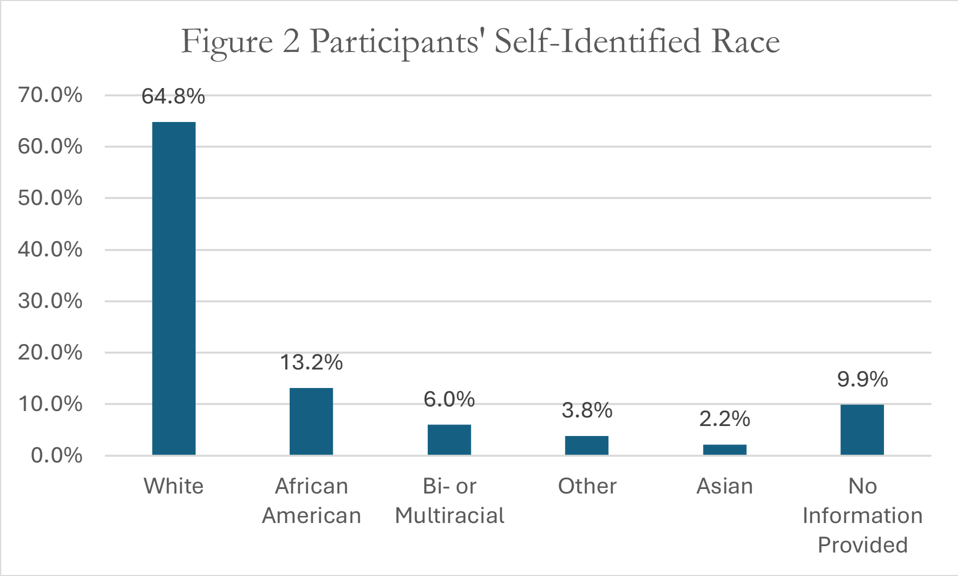


Figure 2 Participants' Self-Identified Race

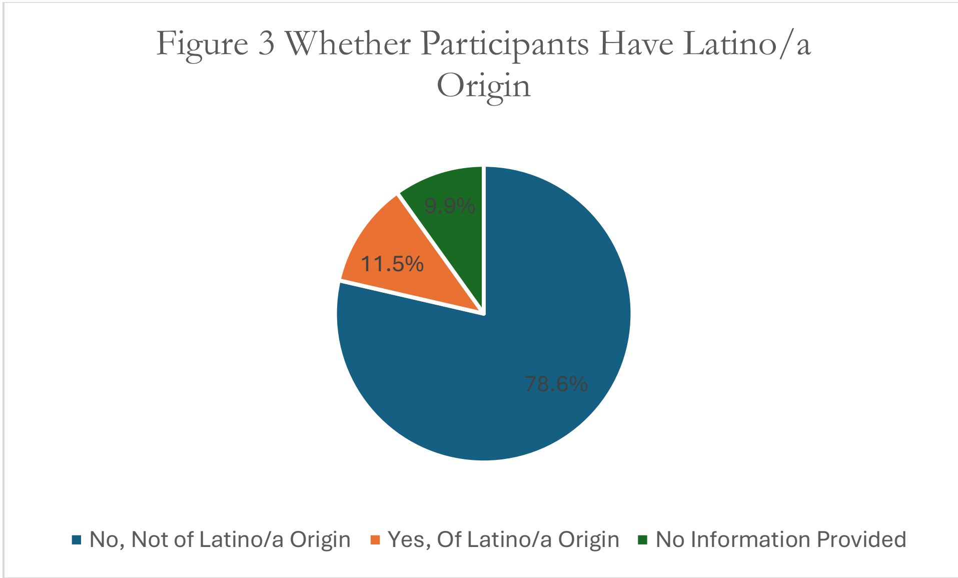
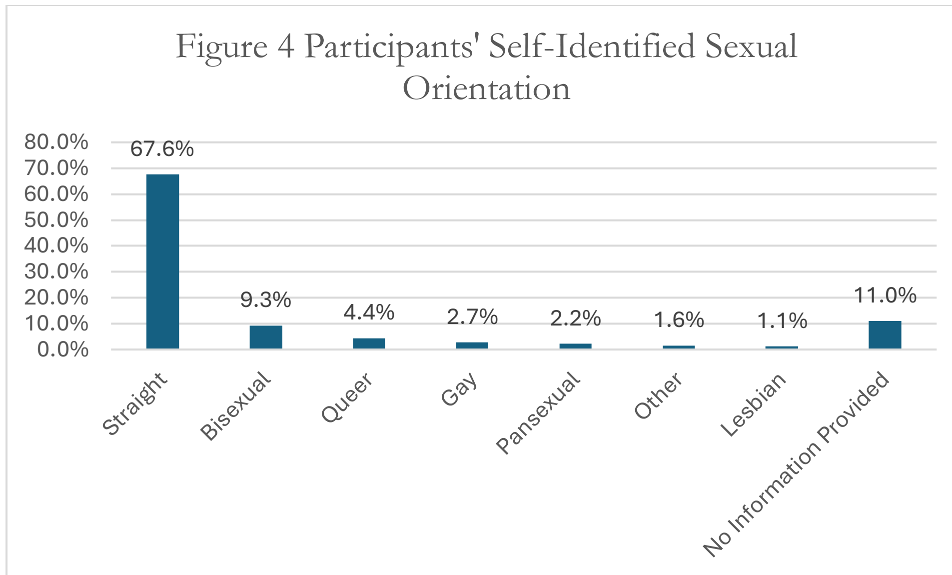
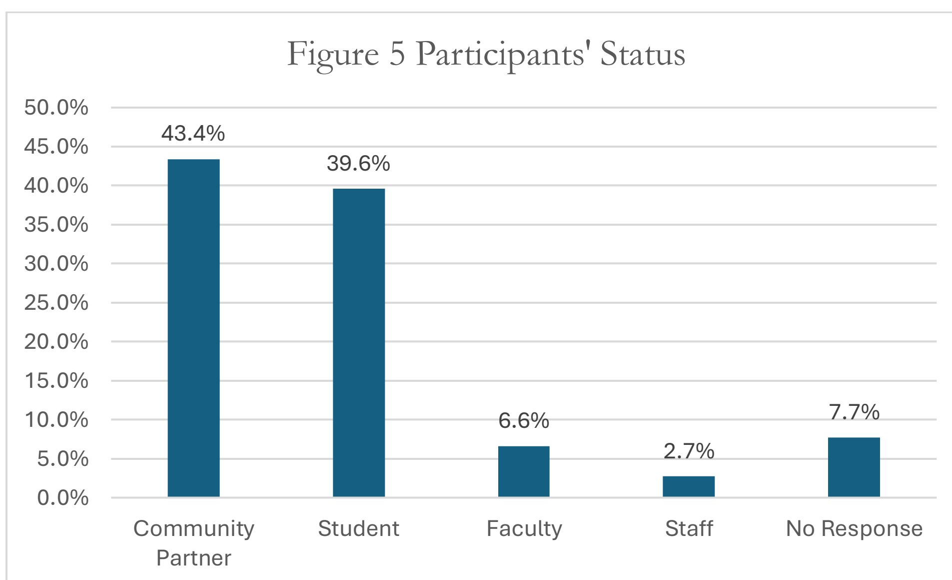


Figure 3 Whether Participants Have Latino/a Origin

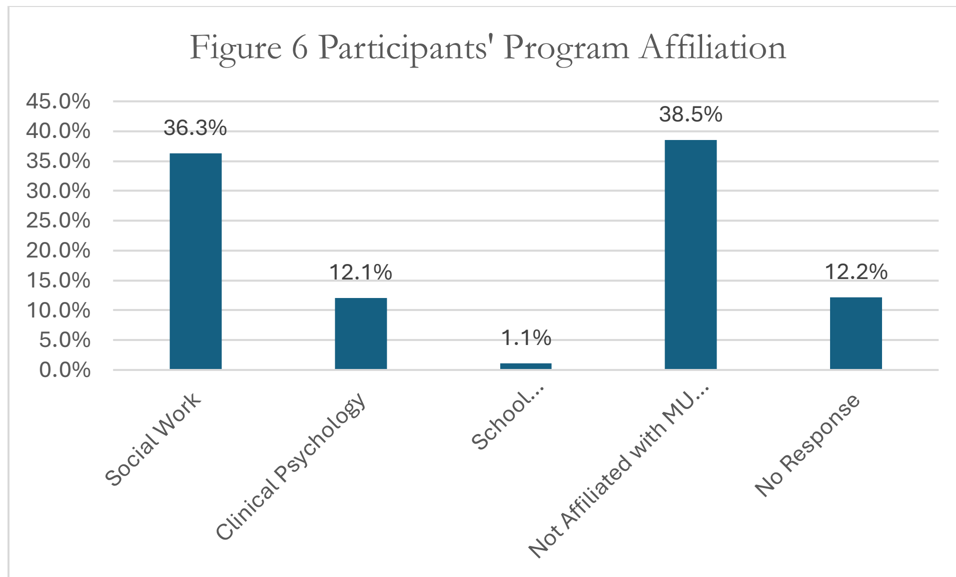
Participants also answered questions about their self-identified sexual orientation. Here, 123 (67.6%) respondents self-identified as straight, 17 (9.3%) as bisexual, eight (4.4%) as queer, five (2.7%) as gay, four (2.2%) as pansexual, three (1.6%) as other, and two (1.1%) as lesbian. 20 (11.0%) participants 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. 79 (43.4%) of the participants said they are community providers, 72 (39.6%) identified themselves as students, 12 (6.6%) identified themselves as faculty, and five (2.7%) identified as staff. 14 (7.7%) respondents did not provide a response for this demographic variable (see Figure 5).



70 (38.5%) did not identify a MU program affiliation, while 22 (12.1%) did not provide a response to this question. 66 (36.3%) participants said they were affiliated with the Social Work department, 22 (12.1%) stated that they were affiliated with the Clinical Psychology program, and two (1.1%) respondents identified themselves as affiliated with the School Counseling/Psychology (see Figure 6 on the next page).

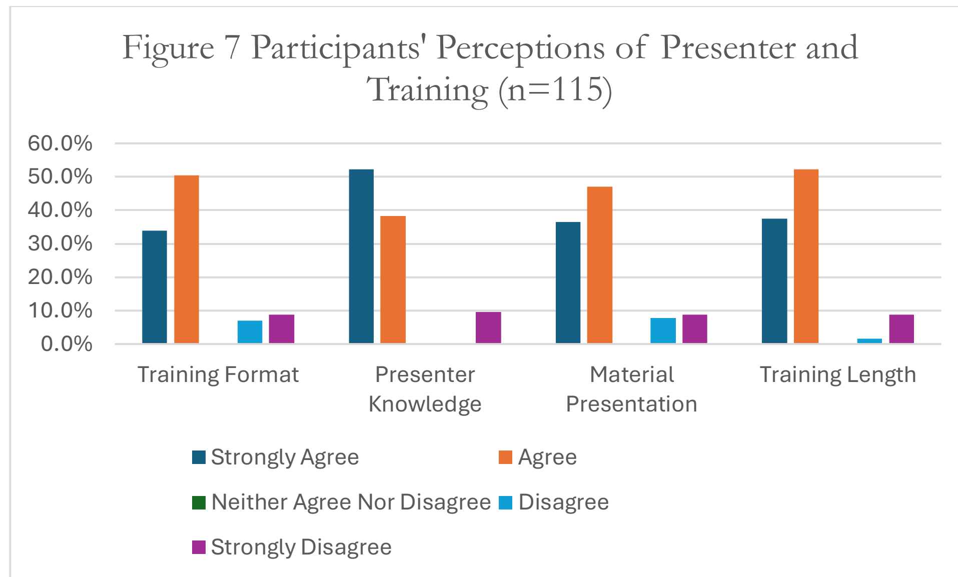


Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 163 (89.6%) participants provided a response while 19 (10.4%) did not do so. Responses ranged from zero to 42 years in the field and the mean was 10.71 years (*SD* = 10.748). The median years worked was seven.

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 115 out of 183 (63.2%) surveys for all items. Overall, participants were positive about the training. Out of all valid responses, 97 (84.3%) participants strongly agreed or agreed that the format for the training met their needs, while 104

(90.4%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 96 (83.5%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 103 (89.6%) 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 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:

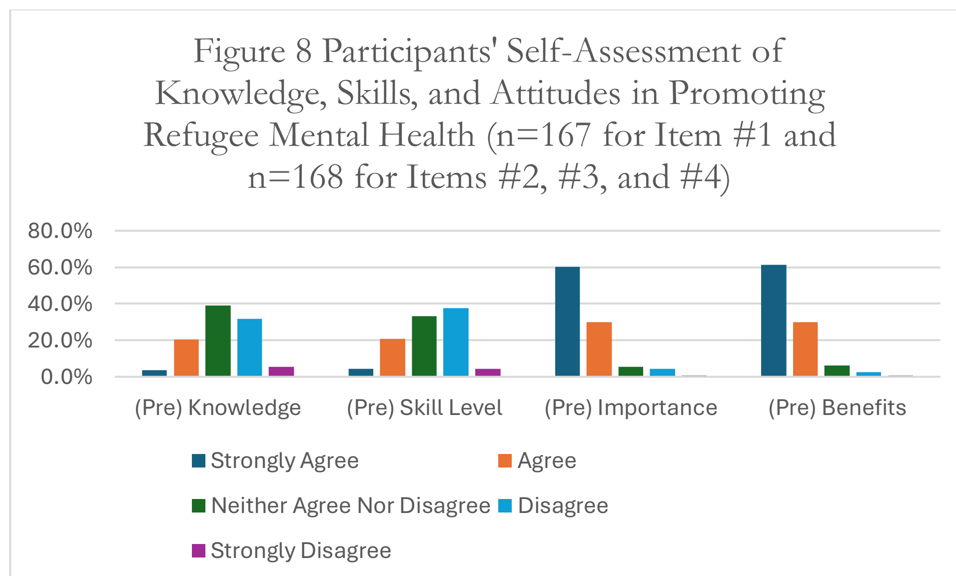
1. I am confident in my current knowledge about mental health challenges and opportunities in the refugee and immigrant communities.
2. I am confident in my current skill level in promoting refugee and immigrant communities' mental health needs.

3. I believe that understanding and applying best practices in promoting mental health in the refugee and immigrant communities is an important component of practice delivery.

4. I believe that understanding how best to promote mental health in the refugee and immigrant communities can provide positive benefits in the delivery of service.

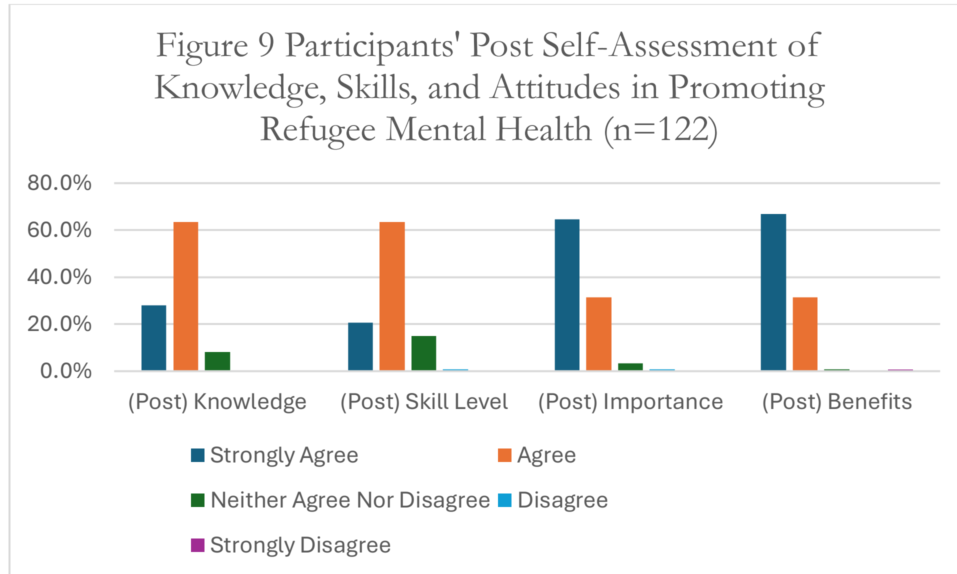
Descriptive Statistics

In the pre-survey, we received 167 valid responses for item #1 and 168 responses for items #2, #3, and #4. Respondents generally rated their attitudes about refugee mental health 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 3.15 for item #1, 3.17for item #2, 1.55 for item #3, and 1.51 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 (see below).



In the post-survey, we received 122 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 1.80 for item #1, 1.96 for item #2, 1.40 for item #3, and 1.36 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 107 respondents who completed both the pre- and post-webinar surveys for item #1 and 108 respondents for items #2, #3, 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 large for items #1 and #2, as Cohen’s d was 1.557 and 1.516 respectively. The effects were smaller for items #3 and #4, as Cohen’s d was 0.324 and 0.306 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. 119 (97.5% of post-webinar participants) participants provided responses

Table 1 **Dependent Samples T-Test Results for Fall 2023 "Promoting Mental Health in the Refugee/Immigration Community: Challenges and Opportunities" Webinar (n=107 for item #1; n = 108 for items #2-4)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about mental health challenges and opportunities in the refugee and immigrant communities.	3.22	1.81	< 0.001
I am confident in my current skill level in promoting refugee and immigrant communities' mental health needs.	3.21	1.99	< 0.001
I believe that understanding and applying best practices in promoting mental health in the refugee and immigrant communities is an important component of practice delivery.	1.67	1.39	< 0.001
I believe that understanding how best to promote mental health in the refugee and immigrant communities can provide positive benefits in the delivery of practice.	1.62	1.36	< 0.001

to the first question, while 116 (95.1% 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 of tremendous benefit overall. There were no major differences in feedback between community providers, students, faculty, and staff. There was only one negative comment, and it focused on the modality (as opposed to the content) of the webinar. This participant stated that while they found the webinar to be information, *"on-line, it was difficult to understand everything that was being said."* This is not a new concern – there are pros and cons for both in-person and online events – and only one participant brought up this issue. Given the overwhelming positive feedback for this webinar, the online format was probably a net positive.

We begin with participants' feedback on the training format. Nine (7.4%) participants indicated that they very much appreciated the format of the webinar, particularly the panel featuring a diversity of voices and perspectives. Three (2.5%) participants also commented that they appreciated the discussion and the opportunity to ask questions. While some of the comments about the webinar format were broad and general (e.g., *"I enjoyed the various areas of knowledge from different fields,"* and *"I enjoyed the panel discussion as the presentation mode. It was insightful."*), others were more specific. One participant appreciated the fact that *"everyone's perspective was (included) on the panel discussion,"* and another appreciated that the panel format enabled *"a broader span of experience (to be) represented."* Yet another participant provided this feedback:

> *Personally, I think the panel was most beneficial for my learning about immigrant and refugee mental health. I really enjoyed hearing all of their different perspectives that they brought to the table.*

> *I think it is important to include speakers that work within different populations of immigrants and refugees.*

Turning to the content of the webinar, participants highlighted three major aspects that they found beneficial: (1) being exposed to experiences (33 participants; 27.7%); (2) learning about available resources (26 participants; 21.8%); and (3) learning about issues with language and translation (11 participants; 9.2%). In their discussion of listening to personal experiences, participants discussed two different aspects: the professional experiences of providers and the personal experiences of refugees and immigrants.

Overall, many participants provided broad and general comments in their appreciation of being exposed to trainers' experiences. When asked what they felt was the most beneficial aspects of the training, participants said they appreciated *"hearing the real-life experiences," "hearing from a panel with unique experiences"* and that *"(i)t was interesting to hear the different options available and different perspectives."* Six (5.0%) participants focused on providers' experiences as the most beneficial aspects of the training. They felt that it was helpful to learn about the challenges that providers face in working with refugee and immigrant behavioral health, as evidenced by a participant who said that they *"appreciated the first-hand knowledge and information from the panelists."* Another participant said that it was helpful for them to *"(hear) the panelists' lived experienced working on the ground with refugees,"* while a third said that the opportunity *"(to get) to ask questions to the panel and hearing directly from the individuals who work with the immigrant and refugee community"* to be most beneficial. One participant felt that the combination of listening to providers' and community members' experiences was especially helpful, saying:

> *It was interesting to hear from a peer who had direct experience with this and has been working as an advocate. Her perspective was very helpful to balance that of the professionals in the community.*

The majority of the participants who cited the opportunity to learn about experiences discussed the impact of listening to members of the refugee and immigrant communities. In particular, many singled out the participation of a young Nepali woman on the panel discussion. It was clear that her presentation had a strong positive impact on many who attended the webinar. Following is a sampling of feedback from webinar attendees about this most beneficial aspect of the webinar.

> *Hearing from the young Nepali woman was so helpful; about that youth forum.*
>
> *I enjoy listening to the testimonial of your panel guest from Nepal. Hearing how she has first-hand experienced these difficulties and challenges within her own family and community reinforces the need for adequate and accessible supports.*
>
> *It was beneficial to hear from Sami regarding survivor guilt, the need for helping put words to trauma experienced, and her experience navigating interpretation of medical providers for her family.*
>
> *Conversations about Sami about what she wishes were available / what she wants providers to know.*
>
> *It was helpful to hear the testimonies of your Nepali panel guests, hearing her story, and personal experiences.*
>
> *I was especially interested in Sami Subedi's experience with Nepali immigrants, because we have quite a few clients from Nepal at my field placement.*
>
> *Hearing from the refugee member of the panel about first-hand experience.*
>
> *Hearing the first-hand account of someone who was a refugee and their experience.*
>
> *Listening to everyone's view, especially the speaker that talked about her parents.*

Second, participants said they found the information on resources to be beneficial. The comments in relation to this major theme were general and broad (e.g., *"community resources," "resource links of interest," "definitely all the resources that were offered."*). There was a sense that webinar attendees were not very aware of resources available to them for working with refugee and immigrant mental health issues, and they were relieved and glad to know that these resources existed. One participant offered that they were *"going to contact CWS for possible*

resources," while another said that they found it beneficial to *"identi(fy) new resources to the community."* Four participants appreciated the information they learned about local resources, and how to locate them, saying that the most beneficial aspects of the training were the following:

> *(Learning) about how to (find) resources for the family*
>
> *Knowing that our county has different agencies helping immigrants and refugees was important for me because I now know where to refer clients that will need this service.*
>
> *Learning about resources that are available in Lancaster.*
>
> *(L)earning about the different ways/resources that can be of benefit for this population. Resources that are often taken for granted.*

Third, and not surprisingly, webinar attendees discussed the benefits and importance of learning about the intricacies of language and translation with providing behavioral health care to the refugee and immigrant communities. Some comments were general and broad (e.g., *"understanding more about translation difficulties and best practices"*). Interestingly, one participant said that they learned about *"(a)lternative mental health options other than talk therapy"* from this webinar training. Participants who commented on this third major theme were thoughtful about what they had learned in regards to language and translation, and especially the impact on providing behavioral health care. For instance, two participants said that they found it beneficial to

> *(hear) about the impact of translation from various angles (medical terminology, kids interpreting for parents and hearing their trauma, not having words for certain things in mental health).*
>
> *(discuss) translation and nuance in having a family member translate versus having a professional translator.*

Another participant also picked on this, saying that it was beneficial for them to participate in

> *(t)he discussion of both the complexity of issues refugee/immigrants may have to address, as well as the strength lens through which to view them. Also, the discussion around what we have words for, i.e.: trauma, that refugees/immigrants may very well not understand.*

A fourth participant said that they

> *found it helpful that there were several presenters, and (to keep) in mind that even with translation service, things are not always communicated as they intend to be.*

Finally, two other participants said they appreciated learning about the intricacies and practical challenges of language and translation (*"(i)t was helpful to learn about the challenges in interpretation services"* and *"specific logistical tips such as working with translators and learning the client's language structures for better translating"*).

Implementation

The participants' responses on what they plan to immediately implement as a result of the webinar training focused on three main areas: (1) increased awareness (39 participants; 33.6%); (2) utilizing the resources (29 participants; 25.0%); and (3) reviewing organizational procedures with refugee and immigrant clients in mind (18 participants; 15.5%).

In terms of increased awareness, many webinar attendees provided broad and general comments, saying that the training had the effect of making them more aware of the challenges that refugee and immigrant clients face. One participant, for instance, said that this training provided them with "*(m)ore understanding and awareness,"* another said they would now bring *"(a)n overall deeper understanding when working with refugee/immigrant individuals."* Among the participants who planned to implement a deeper awareness, they addressed two sub-issues, the first of which is listening to their clients and the second is understanding lived experiences. For instance, one webinar attendee said they planned to *"listen much better,"* while another said they *"will make sure that (they are) attentive to their (clients') needs."* A third attendee signaled that they would be pro-active, saying they planned to

> *(ask) more questions about (clients') experiences and how it influences their care.*

Yet another expressed a sense of humility in implementing their newfound awareness, saying:

> *If I have a client that's from a different culture that I know nothing about – I'll learn about the culture as much as I can before I serve this client.*

This attendee's comments also lead us into the second sub-issue – that of increased cultural competency and awareness. Several attendees talked about how they planned to implement an improved sense of cultural competency and as one attendee put it, *"a better understanding of the refugee experience."* One participant commented on this in length:

> *I believe this training allowed me to grow my knowledge on the types of clients and concerns that will walk into my office. I plan to use the knowledge to improve cultural sensitivity and curiosity. I also hope to use some of the kills they discussed, like giving them forms in their language, ensuring we have the same definitions to words like "depression," using an interpreter, and psychoeducation as needed.*

Second, many webinar attendees also said that they planned to implement the resources they had learned about. They planned to do in two ways – by learning more and looking up more resources, and/or by sharing with their colleagues what they have learned. Attendees said they were pleased to learn about all the resources available for refugee and immigrant mental health, and that would continue to learn more. One participant said that they planned to *"seek additional information for resources in (their) geographic region,"* while a second participant said they planned to *"sign up for refugee newsletter to stay connected to resources,"* noting that they had *"already signed up for Switchboard."* In a similar vein, a third participant shared about the implementation plans:

> *I plan on seeing how I can pull together resources for those in Lebanon County to have on hand, just in case, for my crisis team.*

Yet other webinar attendees planned to implement their training by sharing what they have learned with their colleagues, sharing comments like *"letting my staff know what I've learned,"* and *"share the resources provided during the training with coworkers"* when asked what they planned to implement immediately. A fourth participant said they *"will share resource links with (their) trainees, supervisees, and others on their e-mail list,"* while a fifth said they planned to *"(educate)*

colleagues about the importance of mental health services for refugee populations." A sixth participant reflected on her webinar training, saying

> *I think our (school) district struggles with understanding cultural differences at times. I enjoyed hearing about some of this, as I am hoping to soon speak about this particular population in a Professional Development Day (event).*

By sharing what they've learned with colleagues, webinar attendees are moving towards direct implementation (as compared to an overall improved awareness). A final group of attendees said they would participate in even more direct implementation – by examining their workplace and organizational procedures and policies. Four attendees said they would now reconsider their intake forms, with one saying they would now *"provide choice in how to fill out forms,"* while another said

> *The speakers discussed ways in which counselors can make intake forms more culturally sensitive. I plan on implementing the suggestions that were made as soon as I begin working with clients during my internship, such as having forms available in multiple languages and ensuring that the language used on the form is straightforward.*

The other 12 participants who talked about reviewing their policies and procedures focused on issues of language and translation. One participant said that they would henceforth be *"more aware of wording when using an interpreter,"* while another said they would *"(become) more aware of language barriers."* A third participant shared that they were now *"looking at (their) use of language at school meetings to collaborate better with interpreters."* The majority of these comments focused on translation, whether it be having *"adequate translation services in order to meet (clients') needs,"* or "*(b)eing cognizant of how (they) use interpretation services and who (they) use (family versus third party)."* Two participants also indicated that they would immediately look into ways in which they can translate their documents and brochures and have them be available in multiple languages.

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training were very positive. Participants provided extremely positive feedback, and appreciated the webinar's

showcasing of multiple and diverse perspectives. Webinar attendees seemed genuinely appreciative and felt that they had learned about a client population about which they had not necessarily known much about before.

APPENDIX D

GOAL #3 OBJECTIVE 3(B)

SPRING 2024 "Utilizing the Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community"

Carrie Lee Smith, Katie Shaffer, and Sarah Qundes

Sample Size

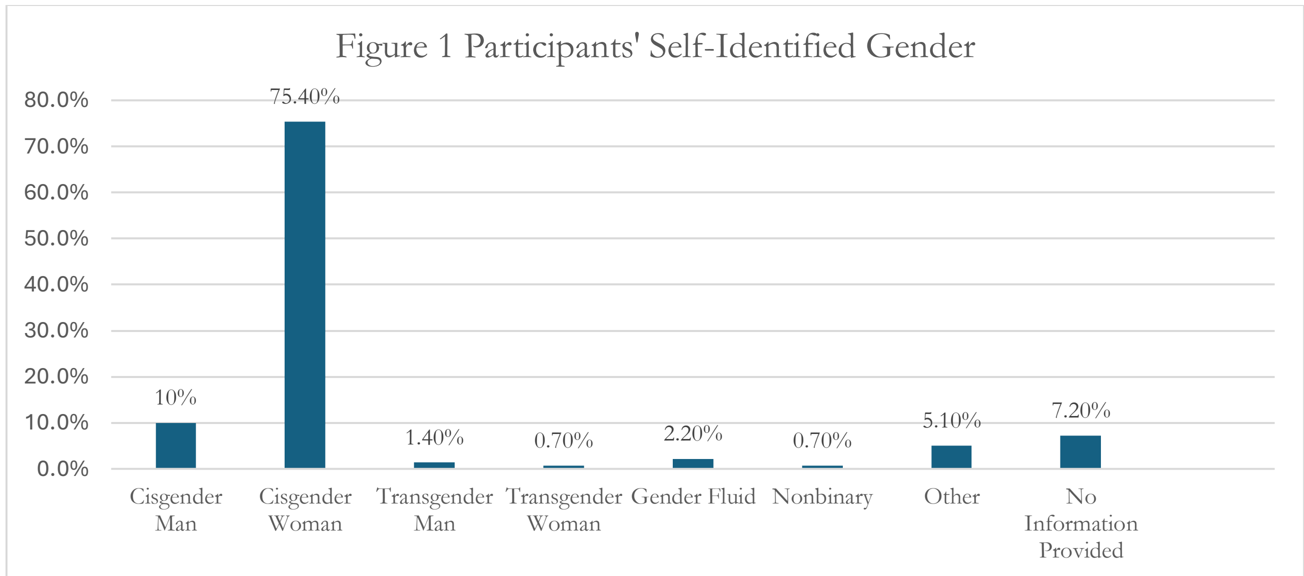
For this webinar training, 36 respondents only filled out the pre-test survey, 7 respondents only filled out the post-test survey, and 95 respondents completed both pre- and post-test surveys. Quite a few respondents completed the same survey twice (or more). For these individuals, we included the first survey they completed, and discarded the second.

Demographics (Based on the Pre-Test Survey)

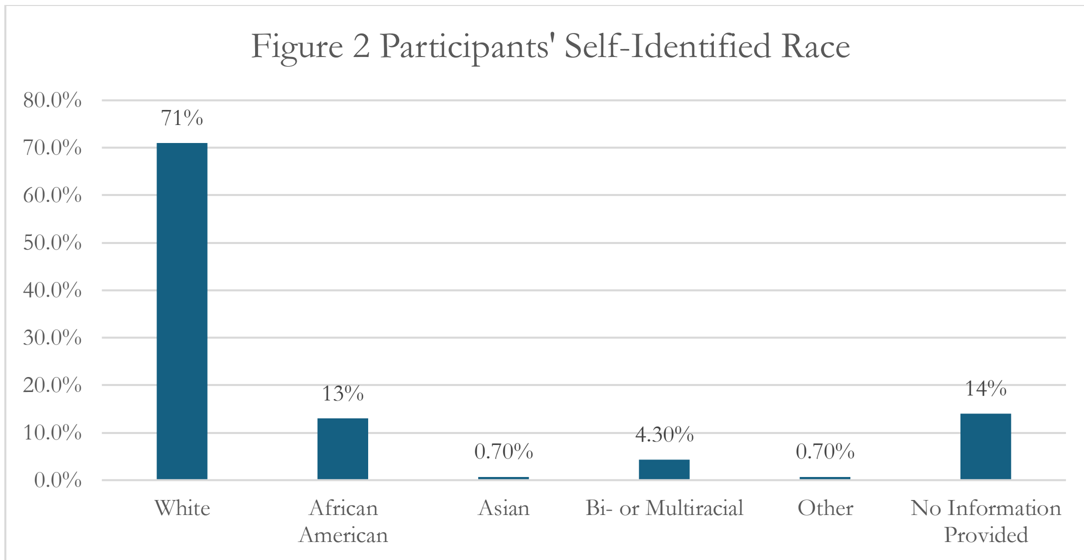
As part of the pre-test survey, participants answered a series of questions about their self-identified gender, race, self-identified sexual orientation, and whether they had Hispanic, Latino/a, or Spanish ancestry. They also identified whether they were a student, faculty, staff, or community provider, 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 138 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 of these, 40.6% identified an affiliation with the Social Work program. Finally, participants stated a mean 10.35 years of experience in a social work-related or behavioral healthcare field. Due to rounding errors, not all percentages add up to 100%.**

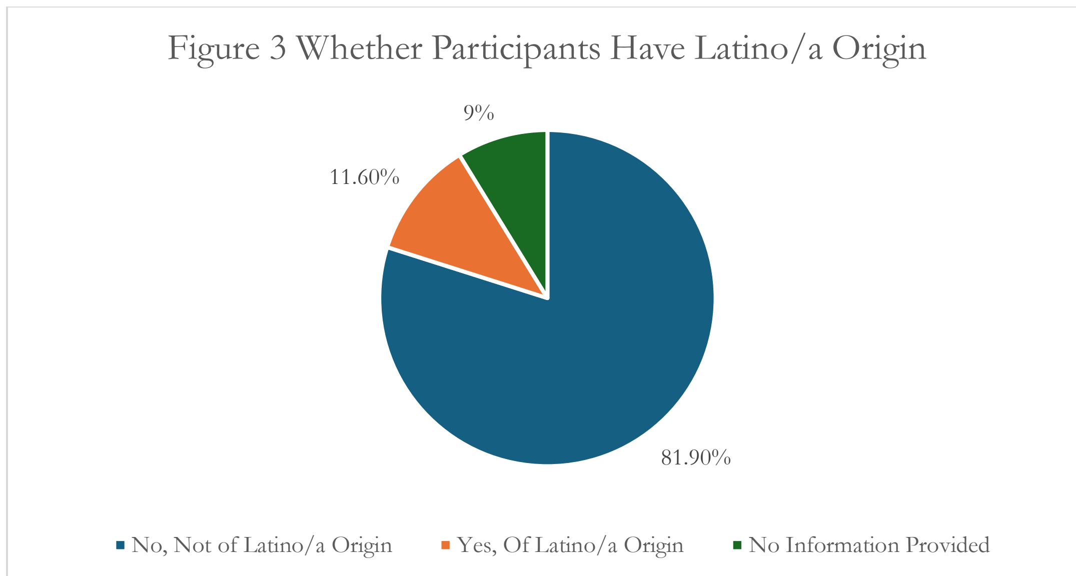
The pre-test sample included 104 (75.4%) respondents who identified as cisgender women, 10 (7.2%) who identified as cisgender men, seven (5.1%) as other, three (2.2%) as gender fluid, and

one (0.7%) as nonbinary. 10 (7.2%) respondents did not provide a response for this demographic variable (see Figure 1).

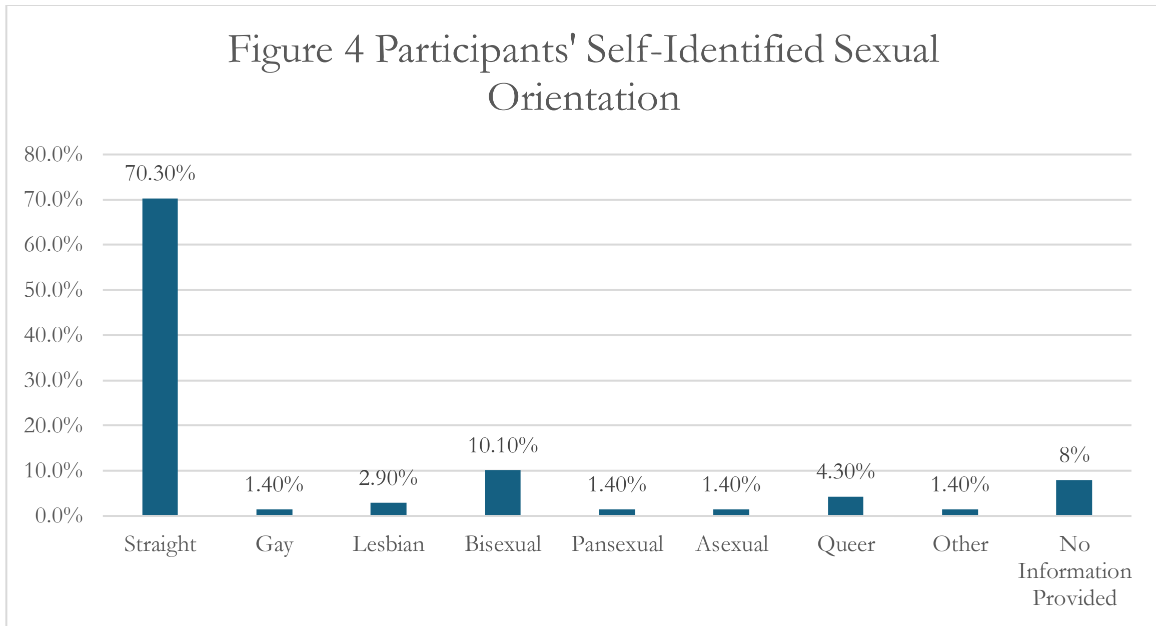


98 (71%) webinar participants self-identified as White, 18 (13.0%) self-identified as African American, 6 (4.3%) self-identified as bi- or multicultural, one (0.7%) identified as Asian, and one (0.7%) identified as other. 14 (10.1%) respondents did not provide a response for this demographic variable (see Figure 2). 113 (81.9%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 16 (11.6%) participants said they did. 9 (6.5%) participants did not provide a response to this demographic variable (see Figure 3).

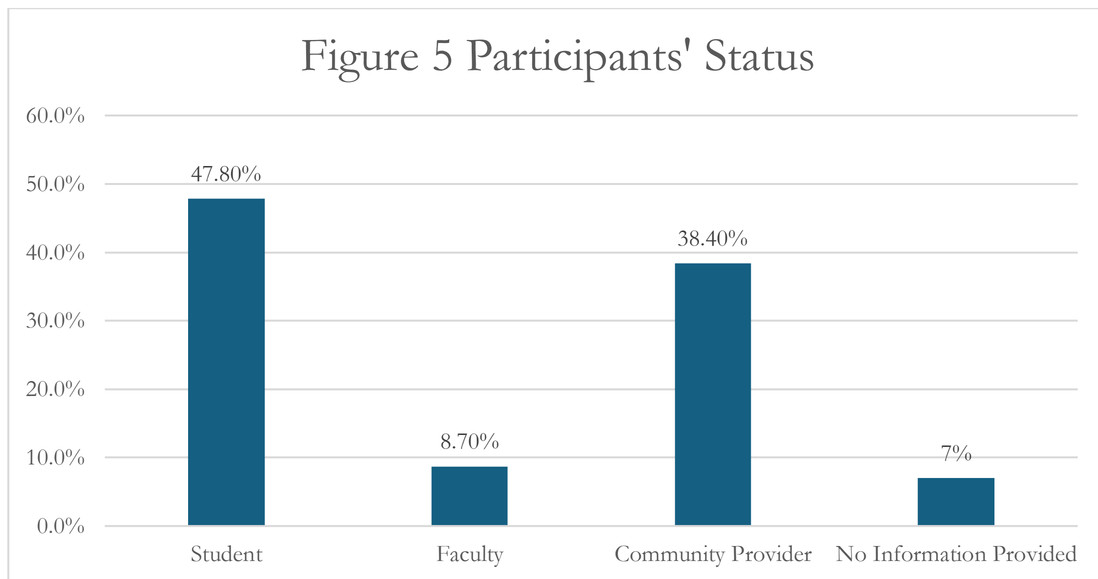




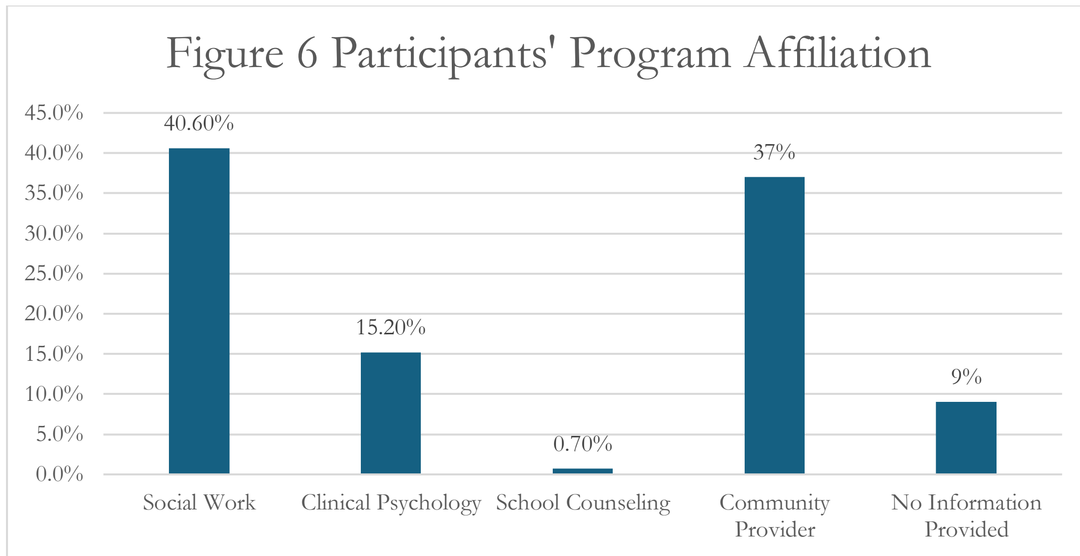
Participants also answered questions about their self-identified sexual orientation. Here, 97 (70.3%) respondents self-identified as straight, 14 (10.1%) as bisexual, two (1.4%) as pansexual, six (4.3%) as queer, two (1.4%) as other, two (1.4%) as gay, four (2.9%) as lesbian, and two (1.4%) as asexual. 8 (5.8%) 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. 66 (47.8%) of the participants said they were students, 53 (38.4%) identified themselves as community providers, and 12 (8.7%) identified themselves as faculty. 7 (5.1%) respondents did not provide a response for this demographic variable (see Figure 5).



51 (37%) identified as a community provider, while 9 (6.5%) did not provide a response to this question. 56 (40.6%) participants said they were affiliated with the Social Work department, and 21 (15.2%) stated that they were affiliated with the Clinical Psychology program. One (0.7%) stated that they were affiliated with the School Counseling/Psychology program (see Figure 6).

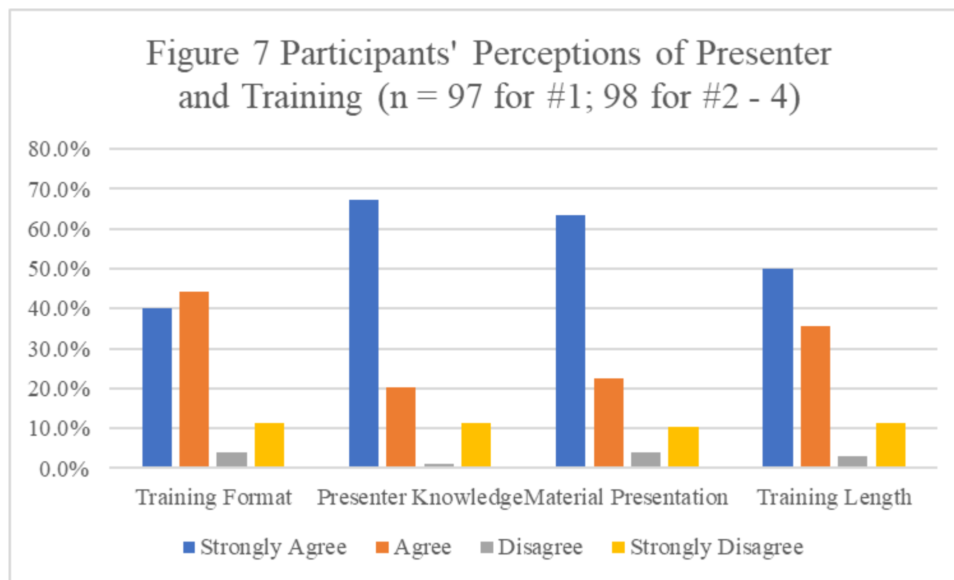


Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 131 (94.9%) participants provided a response while 7 (5.07%) did not do so. Responses ranged from zero to 40.0 years in the field and the mean was 10.35 years (*SD* = 10.437). The median years worked was 7.0.

Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included in 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 97 out of 138 (70.3%) surveys for the first item. For the second, third, and fourth items, responses were provided for 98 out of 138 (71.0%) surveys. Overall, participants were positive about the training. Out of all valid responses, 82 (84.5%)

participants strongly agreed or agreed that the format for the training met their needs, while 88 (89.8%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 84 (85.7%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 84 (85.7%) participants strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7).



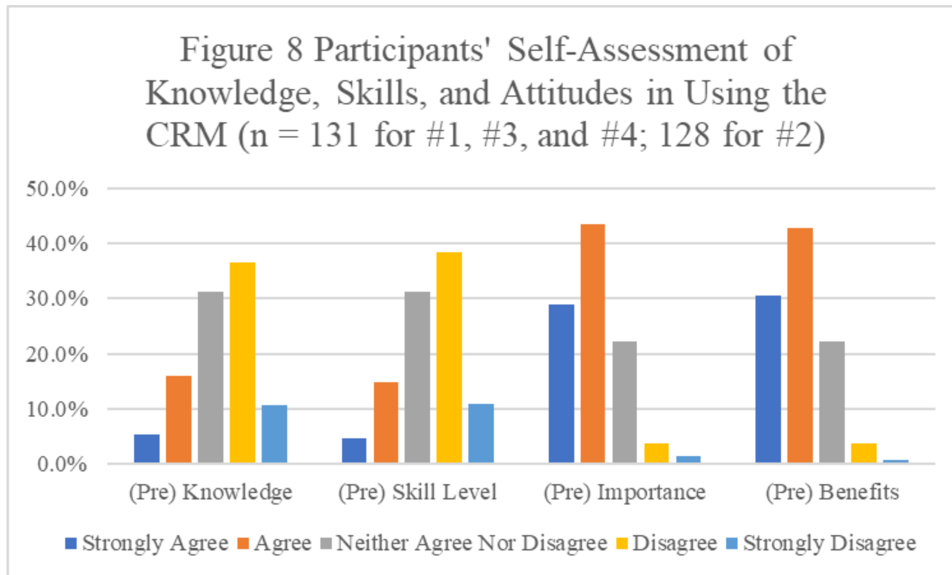
Knowledge, Skills, and Attitudes About "Utilizing the Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community" – Quantitative Data Analysis

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 utilizing the community resiliency model. 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:

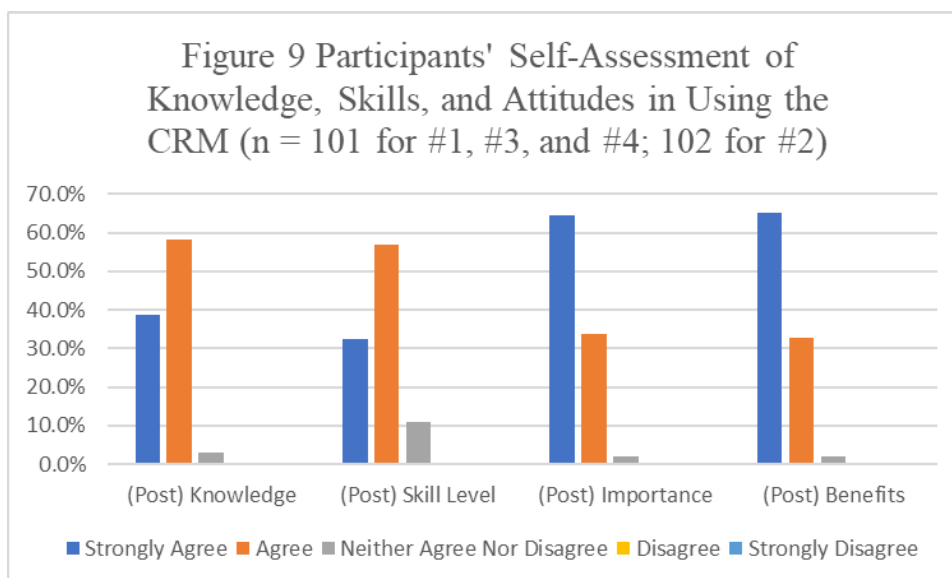
(1) I am confident in my current knowledge about using the community resiliency model to support the mental health of workers and the community.
(2) I am confident in my current skill level in using the community resiliency model to support the mental health of workers and the community.
(3) I believe that understanding and applying best practices in using the community resiliency model to support the mental health of workers and the community is an important component of practice delivery.
(4) I believe that understanding how to use the community resiliency model to support the mental health of workers and the community can provide positive benefits in the delivery of services.

Descriptive Statistics

In the pre-survey, we received 131 valid responses for the first, third, and fourth items. We received 128 valid responses for the second item. Respondents generally rated their attitudes about using the community resiliency model to support the mental health of workers and the community 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 3.31 for item #1, 3.36 for item #2, 2.05 for item #3, and 2.02 for item #4 (medians were 3.0 for items #1 and #2 and 2.0 for items #3 and #4). Responses leaned towards the "positive" end of the scale, as can be seen in Figure 8 (see the next page).



In the post-survey, we received 101 valid responses for the first, third, and fourth items. We received 102 valid responses for the second item. 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 all four items. Means were 1.64 for item #1, 1.78 for item #2, 1.38 for item #3, and 1.37 for item #4 (medians were 2.0 for items #1 and #2 and 1.0 for items #3 and #4) (see Figure 9 below).



Inferential Statistics

For this webinar, we matched 94 respondents who completed both the pre- and post-webinar surveys for items #1, #3, and #4. We matched 93 respondents who completed both the pre- and post-webinar surveys for item #2. 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 large for items #1 and #2, as Cohen's d was 1.522 and 1.459 respectively. The effects were medium for items #3 and #4, as Cohen's d was 0.693 and 0.631 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. 95 (93.1% of participants who completed a post-webinar survey) participants provided responses to the first question, and 92 (90.2% of participants who completed a post-webinar survey) 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 of tremendous benefit overall. Participants' discussion of what they found most helpful often

Table 1 **Dependent Samples T-Test Results for Spring 2024 "Utilizing the Community Resiliency Model (CRM®): Supporting the Mental Health of Workers and the Community" Webinar (n = 94 for #1, #3, and #4; 93 for #3)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about using the community resiliency model to support the mental health of workers and the community.	3.21	1.63	< 0.001
I am confident in my current skill level using the community resiliency model to support the mental health of workers and the community.	3.23	1.77	< 0.001
I believe that understanding and applying best practices in using the community resiliency model to support the mental health of workers and the community is an important component of practice delivery.	1.97	1.37	< 0.001
I believe that understanding how to use the community resiliency model to support the mental health of workers and the community can provide positive benefits in the delivery of practice.	1.94	1.36	< 0.001

blended both content and presentation style – pinpointing a helpful content area, ably discussed and presented by the trainer. Of note, participants did not provide any negative comments. There were also no major differences in how students, faculty, and community providers felt about the training.

Several of the comments were also very general, focusing more on broad themes and areas. For instance, one participant said that "(a)ll the information was helpful," while another said that "(j)ust overall learning about the application of CRM" was most helpful. A third participant acknowledged their lack of background in this area, saying that they "(had) never heard of this model, or at least by name, so it was very useful to dive deeper into each layer of the model."

However, participants identified four key themes to be of major benefit: (1) the use of personal examples and experiences; (2) the discussion of trauma; (3) the discussion of resilience; and (4) the resources provided as well as the focus on skills and interventions. Many comments also incorporated at least two of these four key themes, e.g., finding personal examples very helpful while also appreciating a different way to understand trauma and resilience.

First, many (29; 30.5%) participants said they very much appreciated how the trainer incorporated their personal experiences. When asked what they felt was most beneficial about the training, many participants provided brief feedback like *"the personal examples*," "*personal stories/reflection/examples from presenter*," and "*the presenter's personal stories*." It was clear that participants deeply appreciated the presenter sharing her own experiences. Attendees also felt that she was conversant with the topic, and that her presentation style was engaging, as evidenced by these responses as to what they found most beneficial:

> *Dr. Walsh sharing her personal stories and experiences were so beneficial to help us all better understand how these skills can be used in practice*
>
> *The stories made the presentation very personable and easier to understand*
>
> *How genuine Dr. Walsh was and how she connected the concepts to live(d) experiences*
>
> *Personal stories that helped me understand how the theory plays out in real life*

> *I love Dr. Kay's (sic) style of presentations with real life examples. So inspiring!*
>
> *I enjoyed listening to Dr. Walsh explain her journey of how CRM influenced her life.*
>
> *The speaker was very knowledgeable and kept my attention going. She did a great job!*
>
> *I really appreciated that Dr. Walsh related the CRM to her work at the Red Cross. It is much easier for me to learn new information when the instructor gives real life examples and cases.*
>
> *I found that real life examples were the most beneficial aspects of the training for me. They helped me grasp concepts more effectively and apply them in real-world scenarios, enhancing my understanding and skills.*

Second, some participants (9; 9.5%) said they found the presenter's discussion of trauma to be beneficial. Some of the participants provided general and broad comments, e.g., saying that they found *"trauma informed techniques,"* and "*learning about all the different forms of support system, and understanding, trauma*" to be most beneficial. Other participants provided more specific comments about how they found the discussion on trauma beneficial, including the following:

> *The examples of the ways in which people who have been traumatized may carry that trauma into their life and what types of things may be triggering (particularly in relation to natural disasters)*
>
> *Utilizing the connection between ACEs and Adverse Community Experiences, and the similarities within*
>
> *applying CRM skills with social work practice and trauma informed care*
>
> *I really appreciated the emphasis on taking the blame off the client for having certain reactions to trauma. I also liked the practical skills, like grounding and help now, to use with clients in session.*
>
> *Understanding the correlation between adverse childhood experiences and adult chronic illness*
>
> *The discussion on perspective shifts was most beneficial to me. The link between the adverse childhood experiences and adult chronic illnesses discussion was also beneficial. It brought awareness and understanding to these experiences.*

Third, and interestingly, eight (8.4%) participants said that the part of the training that they found to be most beneficial was the flip side of trauma – the focus on resilience.

Some of the participants offered broad responses relating to this topic, e.g., *"the concept and reminders of resiliency cultivating well-being was most beneficial."* In contrast, other participants provided more detailed responses, connecting the focus on resilience to other topics and to the presenter's style as well, as can be seen from these comments:

> *I appreciated the real-life examples given, as well as the informational aspects of CRM, and resiliency in general.*
>
> *What was most beneficial for the training for me was being able to listen to the community resilience model and then have the activity booklet to be able to see how the concepts she was discussing can be implemented in such a practical way.*
>
> *I found the discussion of the "Resiliency Okay Zone" beneficial to understanding my clients who are struggling with food insecurity and poverty.*
>
> *It was validating to hear about another technique that focuses on strengths instead of deficits.*

Fourth and finally, participants (30; 31.6%) cited the skill sets and the resources they were provided as being the most beneficial aspects of the training. One respondent said they *"love the 6 skills,"* while another said they liked *"(l)earning how to use the skills."* A third respondent said that they found the *"(a)wesome information regarding resources and skills"* to be most beneficial, while yet a fourth said they appreciated learning about *"tangible skills to use."* While participants appreciated the skills they were learning, many participants also emphasized the format in which these skills were shared and presented. Specifically, participants highlighted the usefulness of the handouts and the resources/activity guide. In addition, participants also discussed how the presenter utilized breakout rooms effectively, as seen in the following comments:

> *I liked how Walsh brought in and talked about different resources from this booklet that she created, and had many opportunities to have breakout rooms.*
>
> *I really liked that this training had breakout rooms to be able to be more engaged with my peers, but also with what was being taught. Working in (C)risis, I found a lot of this training to be applicable to what I do.*

> *The exercise in the breakout room was very reflective. We have opportunity (sic) to identify our common well being reaction and how we can utilize them to regulate stressful emotions.*

As with previous webinars, participants appreciated the practical nature of the training. They found information on skills, interventions, trauma, and resiliency to be beneficial. In this training, the presenter's presentation format clearly resonated with the attendees as well. The presenter utilized personal experiences and examples to contextualize the theoretical framework, and was skillful in utilizing breakout rooms and walking participants through the model.

Implementation

The participants' responses on what they plan to immediately implement as a result of the CRM training focused on three main areas: (1) sharing the information more widely; (2) incorporating specific skills and interventions in their work; and (3) being more aware of themselves and their own reactions. As with the previous question, participants often addressed more than one main area in their responses, e.g., saying that they will share the information while also utilizing the information to increase their self-awareness.

16 (17.39%) participants commented that they planned to share what they learned with their colleagues and students, and some also expressed interest in continuing to learn more about the CRM model. For instance, one participant said that they would share *"the model with (their) students,"* while another said that she wants to *"start practicing (the model) on (her) own so that (she) can share it well with others."* (This participant also touches on the third main theme of implementation – using the model to gain more self-awareness.) A third participant said that they plan to *"take this information to (their) current internship*," while a fourth said they planned to "*share with (their) students and club members.*" Some participants provided more specific details on how they planned to share what they've learned, and pinpointed specific concepts as well, as evidenced by the following comments:

share the iChill app with others

sharing the slides with my colleagues

talking more about resilience with my students and discussing common health reactions in addition to common stress reactions

My MSW field placement at Hospice & Community Care were excited that I was attending this training so that I can share this information with them. I am looking forward to sharing it with our teams and our amazing workers out in the field!

I work with community partners on a daily basis – the community resilience model would be beneficial for all orgs to become familiar with

Processing with my team and creating tools to help my students that have gone through something traumatic

I think my biggest immediate takeaway is to help explore and foster community supports of those that I work with. She had some many good examples of how community could help people be resilient in times of disaster. I want to learn more about local community organizations (professional supports, peer supports, and social groups) to help direct people to be more engaged in their community.

I plan to bring this information to my supervisor to discuss how to integrate into our current system.

Second, 26 (28.3%) participants indicated that they would incorporate some of what they've learned from this webinar in their sessions with clients. Some of these comments were broad and did not provide specific information. For instance, one participant said they planned to continue their *"education on the model and continued reading (on) how it can be applied in the inpatient mental health setting,"* while another said they looked forward to *"includ(ing) aspects of CRM as skill building in patient support group(s)."* Several participants provided more in-depth information on specific interventions that they plan to implement. The two most common interventions related to that of tracking and resiliency. In fact, quite a few participants, when asked what they planned on implementing immediately, responded with *"tracking."* These responses were not included in the count since respondents did not clarify how they planned to utilize this intervention.

Participants found the discussion on resilience to be very helpful, with many discussing how they planned to use what they've learned in their work with clients. For instance, one participant said they planned to *"encourage trauma clients to identify positives to motivate them and continuing to encourage them to develop support systems."* A second participant said they planned to implement *"resiliency work with clients,"* while a third participant said they planned to implement *"resiliency focused language as well as some of the thought provoking questions such as what/who lifts you up and gives you strength."* It appears that participants found the tools for interacting with clients about resiliency to be very helpful, as participants also planned to *"ask better questions with clients regarding resilience,"* and introduce the concept of the *"resiliency zone"* to clients. One participant provided a specific and thoughtful response, saying:

> *Throughout the training, I found myself noting ways that I could implement some of these ideas into sessions with my kiddos that would help to empower them and change their mindset when challenging circumstances arrive.*

In addition to resilience, several participants also pinpointed the usefulness of the skill of tracking. For instance, one participant commented,

> *There were multiple activities that I can implement into my work in family based therapy. I am specifically interested in implementing the tracking activities into my therapy sessions.*

A second participant concurred, saying,

> *I would like to practice using the skill of tracking because I think it would be very helpful when working with my adolescent clients with complex trauma.*

A third participant said they planned to *"share these resources with clients starting on Monday, starting with tracking."* Overall, while participants found the entire training to be very useful, and appreciated the variety of resources with which they were provided, many found the interaction skills associated with resilience and the method of tracking to be the most valuable.

Third, eight (8.7%) participants said that the webinar training had encouraged them to be more thoughtful about their approach to self-care. When asked what they planned to implement, two respondents said *"self-care techniques"* and *"being more gentle with (themselves)."* A third participant offered that they planned to use *"the community resiliency model as self-care practice and plan to use it in practice,"* and that they *"really enjoyed this model."* Two participants honed in more specifically on their self-awareness, and one saying they planned to *"pay more attn (sic) to (their) bodily responses to determine if (they're) in the resiliency zone,"* and another saying they *"plan to use this on (themselves) as (they) pay attention to (their) rise and fall in circumstances."*

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training was very positive. Participants provided positive feedback, and appreciated the presenter's knowledge, sharing of personal experiences, and their presentation approach. We found positive statistically significant changes in all four survey items focusing on attitudes, beliefs, knowledge, and skills among participants who attended this training. Many participants who provided comments and feedback on the post-survey indicated an interest and desire to continue to learn about this model, and how it can be used in the provision of behavioral health care.

APPENDIX E

GOAL #3 OBJECTIVE 3(B)

SPRING 2024 "An Introduction to Using Interactive Biblio-Poetry Therapy"

Carrie Lee Smith, Katie Shaffer, and Taryn Nardi

Sample Size

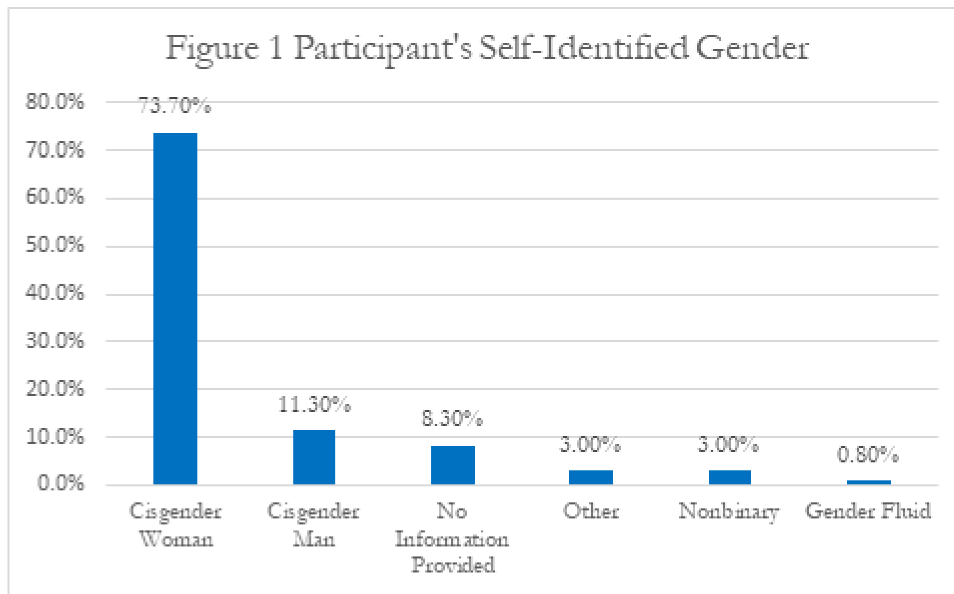
For this webinar training, 30 respondents only filled out the pre-test survey, 7 respondents only filled out the post-test survey, and 96 respondents completed both pre- and post-test surveys. Quite a few respondents completed the same survey twice (or more). For these individuals, we included the first 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 133 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. Of the reported students, 40.6% identified an affiliation with the Social Work program. Finally, participants stated a mean 12.05 years of experience in a social work-related or behavioral healthcare field. Due to rounding errors, not all percentages add up to 100%.**

The pre-test sample included 98 (73.7%) respondents who identified as cisgender women, 15 (11.3%) who identified as cisgender men, four (3.0%) as other, four (3.0%) as nonbinary, and one

(0.8%) as gender fluid. 11 (8.3%) respondents did not provide a response for this demographic variable (see Figure 1 below).



96 (72.2%) webinar participants self-identified as White, 13 (9.8%) self-identified as African American, nine (6.8%) self-identified as bi- or multicultural, two (1.5%) identified as Asian, and two (1.5%) identified as other. 11 (8.3%) respondents did not provide a response for this demographic variable (see Figure 2 on the next page). 111 (83.5%) participants, the majority of the sample, stated that they did not have Hispanic, Latino/a, or Spanish ancestry, while 11 (8.3%) participants said they did. 11 (8.3%) participants did not provide a response to this demographic variable (see Figure 3 on the next page).

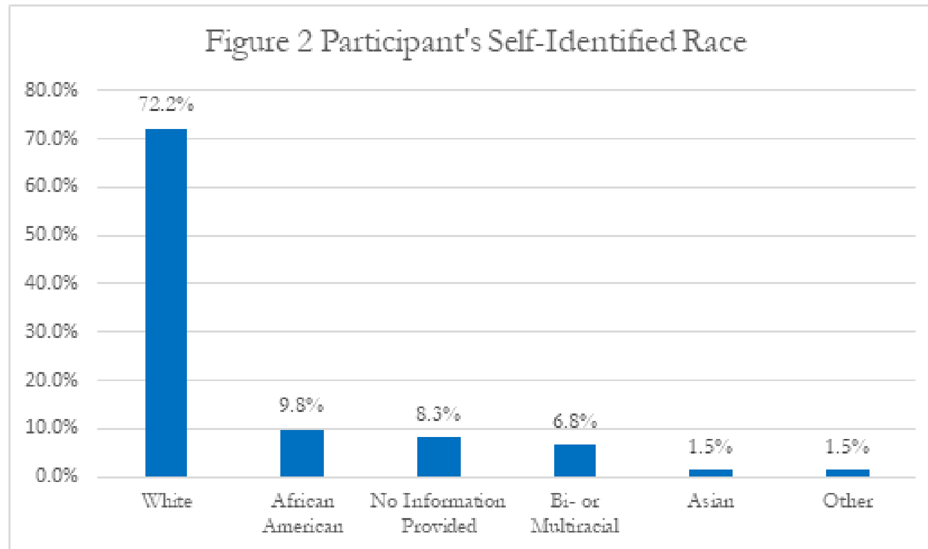


Figure 2 Participant's Self-Identified Race

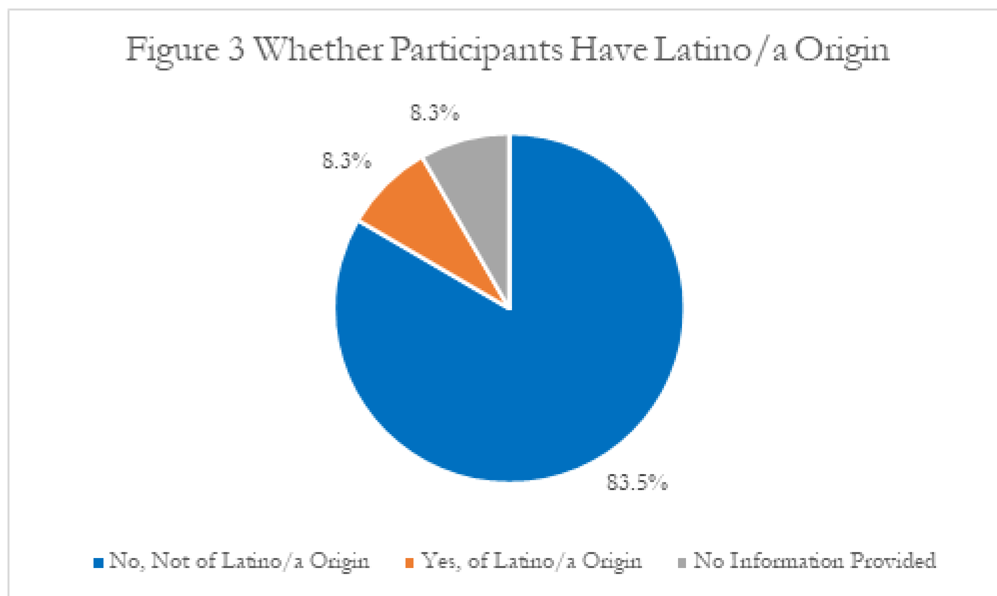
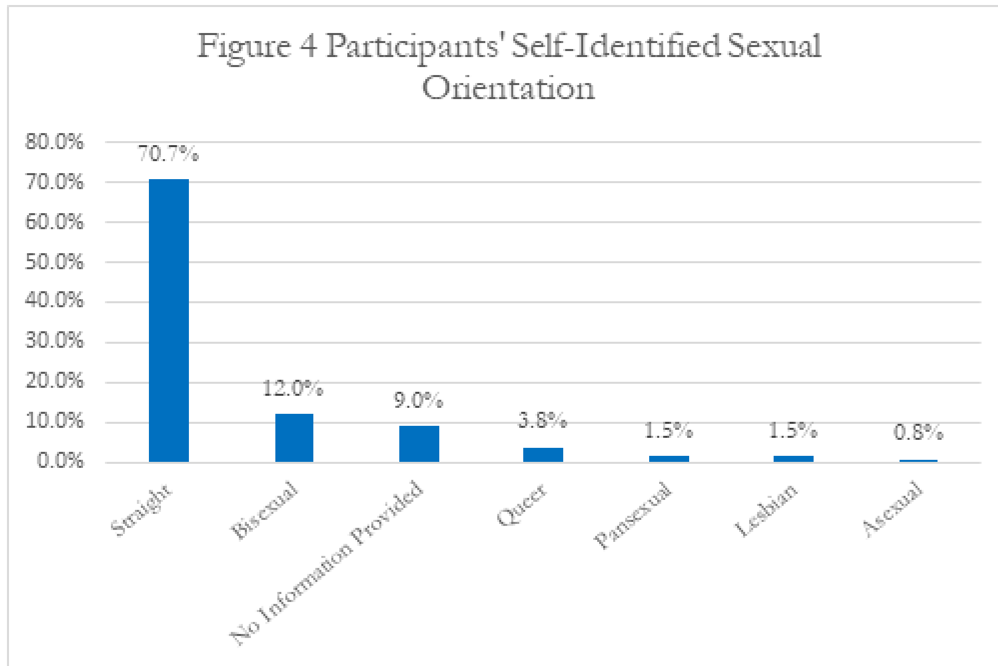
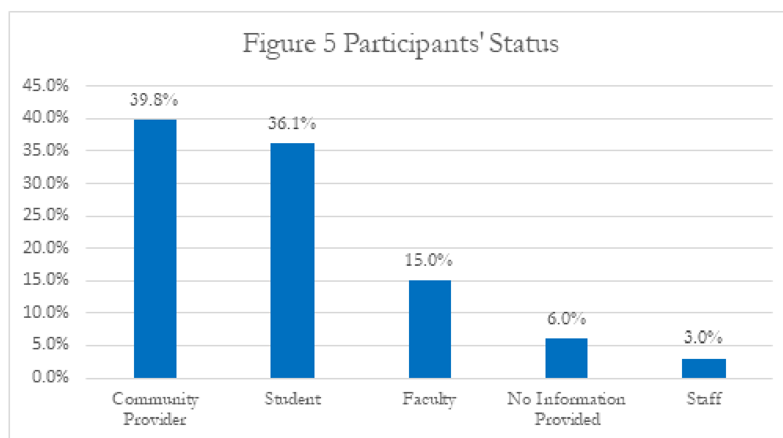


Figure 3 Whether Participants Have Latino/a Origin

Participants also answered questions about their self-identified sexual orientation. Here, 94 (70.7%) respondents self-identified as straight, 16 (12.0%) as bisexual, five (3.8%) as queer, two (1.5%) as pansexual, two (1.5%) as lesbian, and one (0.8%) as asexual. 12 (9.0%) participants declined to provide a response for this demographic variable (see Figure 4 on the next page).

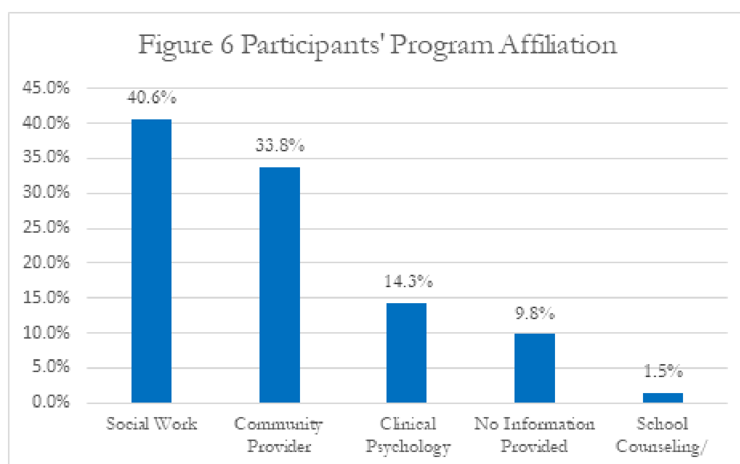


In addition to demographic questions, participants answered questions related to their status and program affiliation (if any) at Millersville University. 53 (39.8%) identified themselves as community providers, 48 (36.1%) of the participants said they are students, 20 (15.0%) identified themselves as faculty, and 4 (3.0%) identified themselves as staff. 8 (6.0%) respondents did not provide a response for this demographic variable (see Figure 5 below).



45 (33.8%) identified as a Community Provider, while 13 (9.8%) did not provide a response to this question. 54 (40.6%) participants said they were affiliated with the Social Work department,

and 19 (14.3%) stated that they were affiliated with the Clinical Psychology program. Two (1.5%) stated that they were affiliated with the School Counseling/Psychology program (see Figure 6 below).

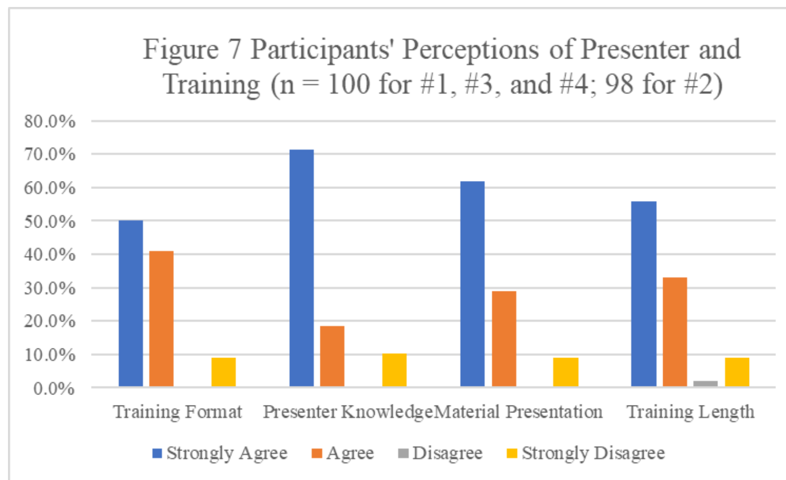


Participants also answered the question, "How many years have you worked in a social work-related or behavioral healthcare field?" 124 (93.2%) participants provided a response while 9 (6.8%) did not do so. Responses ranged from zero to 40.0 years in the field and the mean was 12.05 years (*SD* = 10.941). The median years worked was 8.50.

Participants' Perceptions of the Presenter and Training

Four questions assessing the participants' perceptions of the training were included in 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 133 (75.2%) surveys for the first, third, and fourth items. For the second item, responses were provided for 98 out of 133 (73.7%) surveys. Overall, participants were positive about the training. Out of all valid responses, 91 (91.0%) participants strongly agreed or agreed that the format for the training met their needs, while 88 (89.8%) participants strongly agreed or agreed with the statement, "The presenter was knowledgeable about the topic." 91 (91.0%) participants strongly agreed or agreed that the presenter presented the material in such a way that met their learning needs, while 89 (89.0%) participants

strongly agreed or agreed that the length of training was adequate, given the topic and learning objectives (see Figure 7 below).



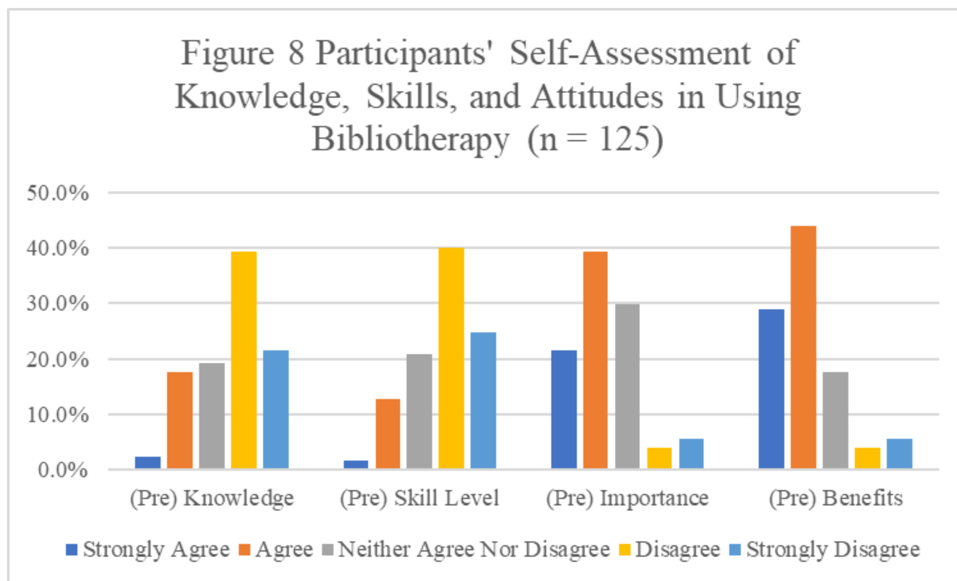
Knowledge, Skills, and Attitudes About Using Interactive Biblio-Poetry Therapy – Quantitative Data Analysis

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 utilizing the community resiliency model. 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:

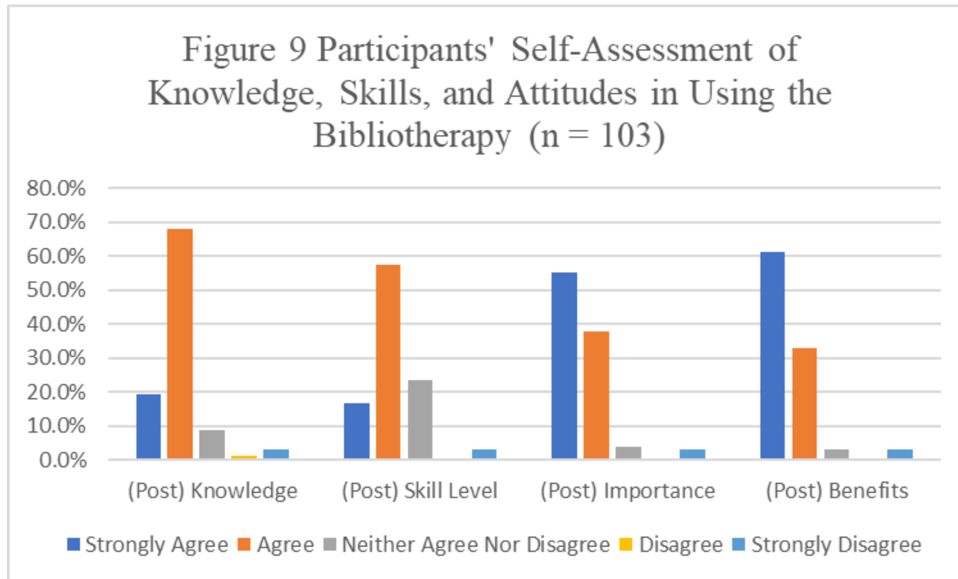
1. I am confident in my current knowledge about using bibliotherapy to work with clients.
2. I am confident in my current skill level in using bibliotherapy to work with clients.
3. I believe that understanding and applying best practices in bibliotherapy to work with clients is an important component of practice delivery.
4. I believe that understanding how best to use bibliotherapy in working with clients can provide positive benefits in the delivery of service.

Descriptive Statistics

In the pre-survey, we received 125 valid responses for all four items. Respondents generally rated their attitudes about using interactive biblio-poetry therapy 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 3.60 for item #1, 3.74 for item #2, 2.33 for item #3, and 2.14 for item #4 (medians were 4.0 for items #1 and #2 and 2.0 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 103 valid 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 all four items. Means were 2.00 for item #1, 2.16 for item #2, 1.57 for item #3, and 1.50 for item #4 (medians were 2.0 for items #1 and #2 and 1.0 for items #3 and #4) (see Figure 9 on the next page).



Inferential Statistics

For this webinar, we matched 96 respondents who completed both the pre- and post-webinar surveys for all four items. 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 large for items #1, #2, and #3, as Cohen's d was 1.356, 1.496, and 0.845 respectively. The effects were medium for item #4, as Cohen's d was 0.689 (following a guideline of 0.8 as indicating a large effect) (see Table 1 on the next page).

Table 1 **Dependent Samples T-Test Results for Spring 2024 "An Introduction to Using Interactive Biblio-Poetry Therapy" Webinar (n = 96)**

Item	Pre-Mean	Post-Mean	Significance
I am confident in my current knowledge about using bibliotherapy to work with clients.	3.60	2.00	< 0.001
I am confident in my current skill level in using bibliotherapy to work with clients.	3.74	2.16	< 0.001
I believe that understanding and applying best practices in bibliotherapy to work with clients is an important component of practice delivery.	2.33	1.57	< 0.001
I believe that understanding how best to use bibliotherapy in working with clients can provide positive benefits in the delivery of service.	2.14	1.50	< 0.001

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. There were 94 (91.4% of post-webinar participants) unique responses to the first question, and 90 (87.4% of post-webinar participants) unique 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 of tremendous benefit overall. Of note, participants did not provide any negative comments. There were also no major differences in how students, faculty, and community providers felt about the training.

Compared to previous webinars, there were more responses where participants stated that they had not been aware of this skill/intervention. For instance, one participant said that *"it was a wonderful training and (they) would love to learn more,"* while a second participant said that *"(they'd) never heard of bibliotherapy and its therapeutic nature and tools that can be used with clients."* A third participant said that what they found most beneficial was that through this training, they were able to *"understand what bibliotherapy really is."* In a similar vein, a fourth participant said that they *"thought everything was information as (they) have never heard of bibliotherapy."* Finally, a fifth participant offered that what they found most beneficial was *"just the topic itself. (They) had not heard of it prior to this training."* Clearly, bibliotherapy is less widely known for this group of webinar attendees. However, the response overall was very positive, with respondents saying that *"the entire training was great," "the presenter was excellent,"* and that *"this one (training) was excellent."*

The majority of the comments were also very general, focusing more on broad themes and areas. However, participants identified two key themes to be of major benefit: (1) the opportunities for hands-on exercises; (2) the variety of examples provided, as well as an explanation of how to apply the examples in behavioral health care delivery. Many comments also incorporated at least two of these three key themes, e.g., appreciating the opportunities for hands-on practice as well as the variety of examples provided.

First, many (21; 22.3%) participants said they very much appreciated the many opportunities to practice skills in real time during the training. In addition to the content of what they were learning about bibliotherapy, participants felt that the format in which this content was being delivered was highly beneficial as well. Many participants, when asked what aspects of the training were most beneficial to them, provided feedback like *"the hands-on pieces*," "*the breakout sessions and the chance to write*," "*the "trying it" sessions,*" and *"the interactive part to do these exercises!"* It was clear that participants deeply appreciated the presenter providing time and space to engage in these bibliotherapy activities, as further evidenced by these comments about what they found most beneficial about the training:

> *Doing the practices with writing. Excellent training materials and scholarship. Super great presenter, accessible, helpful. Wonderful.*
>
> *experiential exercises and also the trauma-informed facilitation that was role-modeled*
>
> *It was awesome to follow along with some activities to see how effective they can be with different populations.*
>
> *I enjoyed how the presenter taught information on bibliotherapy and then provided listeners with exercises to practice.*
>
> *I liked being able to practice some of the things being taught throughout the training.*
>
> *Personally, I really appreciated that the presenter had hands-on activities to make our own bibliotherapy as examples. Writing our own poems made the training far more engaging and individualized. I think it is important for social workers to experience their therapy technique (bibliotherapy) before they use it with their clients. I liked the bibliopoetry exercises and break-out rooms because they made this training more interactive.*

Second, several participants (27; 28.7%) said they found the range and variety of examples provided by the presenter to be beneficial. These participants felt that not only did they learn about many new interventions and resources, they also derived helpful ideas for how to implement them. Two participants provided general and broad comments, e.g., saying that they found *"the variety of approaches"*, and "*lots of new ideas to use with clients"* to be most beneficial. Other participants provided more specific comments, including the following:

I loved all the examples of how to use this in practice.

It was helpful to hear about the ways in which the facilitator has implemented bibliotherapy, such as after a client has lost a parent. It was nice to hear real life examples.

I loved hearing about the different interventions that I could utilize in my own work. Presenter did a great job with explaining the basis for this type of therapeutic approach while also providing different ways to integrate it.

I enjoyed the copious amount of examples and resources given to use with clients – it was very practical.

I loved all the examples of how to use this in practice.

I really loved that the presenter provided specific examples that we can use and try with clients.

I thoroughly enjoyed the examples given in how to use the resources with clients.

I found the prompts really helpful and saw a lot of ways I can use this with some of my current clients.

As with prior webinars, participants appreciated the practical nature of the presenter's discussion of how to adapt bibliotherapy in interactions with clients, and found specific tips and hints on implementation to be beneficial.

Implementation

The participants' responses on what they planned to immediately implement as a result of the bibliotherapy training were somewhat different from previous webinars'. For this webinar, participants named specific interventions and skills, usually without additional context or explanation. In addition, likely because the topic is new to more participants than usual, several participants (13; 14.4%) said that they would like to learn more about bibliotherapy before implementation. Here is a sampling of these participants' responses:

Read more about bibliotherapy, start writing!

I will do more research.

I need more training.

Researching more on the topic to use with clients.

Do more research on this topic and identify how to connect my client that can benefit to the resources

I am going to think more on this. I want to be more creative in the work and with my patients

I plan on researching certification on this and using the methods we learned for my own self-care.

Most of the participants said that they would implement specific interventions, without any elaboration on how they would do so. The most frequently mentioned interventions included the following, as seen in Table 2 below. Many participants included more than one intervention that they planned to implement in their responses. For instance, one participant said they *"plan(ned) to implement poetry into (their) group work,"* and that *"(i)n addition to that, (they'd) like to utilize 5 minute sprints, cluster mapping, character sketches, and 6 word memoirs."* Clearly, with this particular training, more so than previous trainings, participants pinpointed specific interventions that they felt they could immediately implement.

Table 2 Interventions Participants Plan to Implement As Result of Training (n=90)

Intervention	Number of Mentions	Percentage of Responses
journal prompts / journaling	21	23.3%
poetry	8	8.9%
clustering activity	7	7.8%
6-word memoir	5	5.6%
writing metaphors	4	4.4%

Some participants did provide more in-depth information on how they would implement specific interventions. For instance, one participant stated that while they were not in direct practice, they plan to *"set intentions in class and then (check) in with a word cloud at the end of class*," saying that they felt this was a *"great tool (they) might use."* A second participant shared that they *"(had) a client experiencing immense grief right now so (they) plan on using the grief in 6 words exercise to begin the discussion."* Yet a third participant focused on how techniques of bibliotherapy might be helpful for a particular client population, writing:

> *Because poetry provides a medium for individuals to express their thoughts, feelings, and experiences in a creative and symbolic manner, I want to start implementing this technique with my clients that have difficulties expressing their thoughts and feelings due to their anxiety.*

In a similar vein, a fourth participant discussed their plan to implement the clustering technique, saying:

> *One thing I plan on using immediately is the "clustering" bibliotherapy technique, where we mindlessly write down things that make us feel supported and things that we are struggling with. This has helped me (and will help my clients) to physically see a cluster of what is going on in their life and make balance of their struggles and supports. Another thing I already utilized was writing down racing thoughts at night and leaving it for the morning. As someone who has anxiety (especially at night), this technique helped me put my thoughts down and decrease my mental load before bed. I noticed with this, I slept better, and I will be sharing this technique with my clients.*

CONCLUSION

As mentioned earlier, the response and feedback from participants to this webinar training were very positive. Participants provided positive feedback, and appreciated the presenter's interactive and hands-on approach to discussing bibliotherapy. We found positive statistically significant changes in all four survey items focusing on attitudes, beliefs, knowledge, and skills in regards to bibliotherapy. Compared to previous trainings, more participants indicated that this was a new topic for them. However, the interest in this topic is clearly high, and participants indicated that they were interested in learning more and also immediately implementing specific interventions.

APPENDIX F

PRIME Survey Analysis

Carrie L. Smith

Sample Size

The PRIME program participants completed two surveys: one at the beginning of the 2023-2024 academic year and one at the end. There was a total of 66 surveys completed at the beginning of the year. At the end of the year, 63 surveys were completed. Using the participant's MU number or name, the surveys were then matched. 60 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. In analyzing the demographics of the survey respondents, we focus on the 60 PRIME program participants who completed both pre- and post-program surveys.

50 (83.3%) women and 10 (16.7%) men made up this survey sample. 45 (75.0%) of the participants identified as White, nine (15.0%) identified as African American, four (6.7%) identified as Bi- or Multiracial, one (1.7%) identified as American Indian or Alaska Native, and one (1.7%) identified as Asian. The majority of the sample (n = 52, 86.7%) said they did not have Hispanic, Latino/a, or Spanish ancestry, while eight (13.3%) participants reported that they did. Participants also answered questions about their self-identified sexual orientation. Of the 60 participants who completed both pre- and post-program surveys, 45 (75.0%) identified as heterosexual, nine (15.0%) identified as bisexual, three (5.0%) identified as gay or lesbian, two (3.3%) identified as queer, and one (1.7%) identified as pansexual (see Table 1 on the next page).

Table 1 Demographics of Survey Respondents (n=60)

	Number of Participants	Percent
Self-Identified Gender		
Woman	50	83.3%
Man	10	16.7%
Self-Identified Race		
White	45	75.0%
African American	9	15.0%
Bi- or Multiracial	4	6.7%
American Indian or Alaska Native	1	1.7%
Asian	1	1.7%
Participant is of Hispanic, Latino/a, or Spanish ancestry		
Yes	8	13.3%
No	52	86.7%
Self-Identified Sexual Orientation		
Heterosexual	45	75.0%
Bisexual	9	15.0%
Gay or Lesbian	3	5.0%
Queer	2	3.3%
Pansexual	1	1.7%

Note: Percentages may not add up to 100% due to rounding errors.

In addition to demographic questions, participants answered questions related to their role and program affiliation at Millersville University. 28 (46.7%) of the participants were students, nine (15.0%) were faculty, and 23 (38.3%) were community providers. 26 (46.7%) respondents said they were affiliated with the Social Work program, while 13 (21.7%) said they were affiliated with the Clinical Psychology program (see Table 2 on the next page). We should note a discrepancy between those who identified themselves as student/faculty (n=37) and those who identified a program affiliation at MU (n=39). This is due to the fact that, often, community partners identify a program affiliation, even though the survey clearly asks them to do so only if they have faculty, staff, and/or student status at MU. Finally, participants in the pre-program survey reported a minimum and maximum of 0 and 45 years of experience in the field, with a mean of 13.18 years and a median of 10.00 years (st dev = 11.41).

Table 2	Participant Role and Program Affiliation	
	Number of Participants	Percent
Participant Role		
Student	28	46.7%
Community Provider	23	38.3%
Faculty	9	15.0%
Participant Program		
Social Work	28	46.7%
Clinical Psychology	13	21.7%
Not affiliated with MU program	19	31.7%

Note: Percentages may not add up to 100% due to rounding errors.

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. 52 survey respondents had a pre-test ISVS-21 score, while 59 survey respondents had a post-test ISVS-21 score.

PRIME participants' pre-test scores on the ISVS-21 ranged from 3.48 to 7.00. At the end of the cohort year, participants' post-test scores on the ISVS-21 ranged from 4.57 to 7.00. On a scale of 1 to 7, we might look at what percentage of participants scored below 3.5 – the midpoint. For the pre-test survey, only one (1.9%) respondent scored below the midpoint, while all respondents in the post-test survey scored above the midpoint. This indicates 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=5.88, SD=0.73) to Time 2 (M=6.21, SD=0.63), $t(51)$, $p=0.002$ (two-tailed). The mean increase in ISVS-21 scores was 0.33, with a 95% confidence interval ranging from 0.13 to 0.54. The eta squared statistic (0.17) 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 2023-2024, 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, 81.7% of respondents scored as competent, and post-test, this percentage increased to 95.0%. In addition, a paired-samples t-test was conducted to evaluate the impact of the PRIME training on this subscale, which consisted of items 7, 12, 15, 17, and 19 on the full scale. There was a statistically significant increase in *Multicultural Knowledge* scores from Time 1 (M=13.75, SD=2.59) to Time 2 (M=15.7, SD=2.71), $t(60)$, $p=0.001$ (two-tailed). The mean increase in *Multicultural Knowledge* scores was 1.95, with a 95% confidence interval ranging from 1.23 to 2.67. The eta squared statistic (0.33) indicated a large effect size. This means that over the course of the PRIME training for 2023-2024, 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, 98.3% of respondents scored as competent, and post-test, this percentage stayed the same. 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=10.30, SD=1.08) to Time 2 (M=10.67, SD=1.47). However, this increase was not statistically significant (p=0.09 (two-tailed)). This means that over the course of the PRIME training for 2023-2024, we could not determine if 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, 93.2% of respondents scored as competent, and post-test, this percentage increased to 98.3%. 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=20.57, SD=2.25) to Time 2 (M=21.46, SD=3.02). However, this increase was not statistically significant (p=0.052 (two-tailed)). This means that over the course of the PRIME training for 2023-2025, we could not determine if 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, 63.3% of respondents scored as competent, and post-test, this percentage increased to 86.7%. 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=20.52, SD=3.72) to Time 2 (M=22.73, SD=3.51), $t(59)$, p=0.001 (two-tailed). The mean increase in scores was 2.22, with a 95% confidence interval ranging from 1.28 to 3.16. The eta squared statistic (0.27) indicated a large effect size. This means that over the course of the PRIME training for 2023-2024, participants felt that they possessed, on average, <u>more</u> knowledge of socio-cultural diversities at the end than at the beginning.

<u>Self-Reported Confidence in Telehealth KSAs Scale</u>

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=35.38, SD=5.47) to Time 2 (M=38.62, SD=4.50), $t(59)$, $p=0.001$ (two-tailed). The mean increase in scores was 4.58, with a 95% confidence interval ranging from 1.88 to 4.58. The eta squared statistic (0.28) indicated a large effect size. This means that over the course of the PRIME training for 2023-2024, 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, 99.40% 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 an increase in scores from Time 1 (M=60.38, SD=9.77) to Time 2 (M=31.09, SD=7.00). However, the results for this subscale were not statistically significant (p=0.856 (two-tailed test)). This means that over the course of the PRIME training for 2023-2024, we cannot determine if 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=29.98, SD=3.85) to Time 2 (M=31.34, SD=3.38), $t(57)$, p=0.009 (two-tailed). The mean increase in scores was 1.36, with a 95% confidence interval ranging from 0.36 to 2.36. The eta squared statistic (0.12) indicated a moderate (close to large) effect size. This means that over the course of the PRIME training for 2023-2024, 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 106. At the end of the cohort year, participants' post-test scores on the instrument ranged from 23 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, 55.6% of the respondents scored above the midpoint on the scale. In the post-test surveys, 65.6% 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=64.14, SD=23.33) to Time 2 (M=70.08, SD=21.36), $t(50)$, $p=0.008$ (two-tailed). The mean increase in scores was 5.94, with a 95% confidence interval ranging from 2.15 to 10.26. The eta squared statistic (0.13) indicated a moderate (close to large) effect size. This means that over the course of the PRIME training for 2023-2024, 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).

Table 3 Summary of Statistical Analyses and Results for the 2023-2024 PRIME Survey

Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
Interprofessional Socialization and Valuing Scale-21 (ISVS-21)			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
5.88	6.21	p=0.002	0.17
(0 to 7)			
California Brief Multicultural Competence Scale (CBMCS)			
Multicultural Knowledge			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
13.75	15.70	p=0.001	0.33
(5 to 20)			
Sensitivity & Responsiveness to Consumers			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
10.30	10.67	not significant	
(3 to 12)			
Awareness of Cultural Barriers			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
20.57	21.46	not significant	
(6 to 24)			
Socio-Cultural Diversities			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
20.52	22.73	p=0.001	0.27
(7 to 28)			
Self-Confidence in Telehealth KSAs Scale			
Knowledge			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
35.38	38.62	p=0.001	0.28
(15 to 75)			

Table 3 Summary of Statistical Analyses and Results for the 2023-2024 PRIME Survey (Continued)

Self-Confidence in Telehealth KSAs Scale			
Skills			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
60.88	61.09	not significant	
(15 to 75)			
Attitudes			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
29.98	31.34	p=0.009	0.12
(7 to 49)			
Confidence in Coping with Patient Aggression Instrument			
Pre-Test Mean	Post-Test Mean	Significance	Effect Size (Eta)
64.14	70.08	p=0.008	0.13
(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.

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, 11 (39.3%) stated that they intend to pursue employment in a career serving at-risk children, adolescents and/or transitional age youth. Four (14.3%) said they intend to become employed or pursue further training in a medically underserved community, three (10.71%) said they intend to become employed or pursue further training in a rural setting, and two (7.14%) said they intend to become employed or pursue further training in a primary-care setting. Eight (28.57%) 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, 14 (50.0%) indicated that telehealth provision and training was part of their internship. Most of the responses were general, and several only provided an estimate of the number of hours for which they provided services, ranging between five to 50 hours (mostly clustering around 25-35 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, 18 (64.3%) indicated that they had obtained employment and were currently employed. For those who indicated that they are currently employed, the types of agencies at which they worked varied from behavioral care to education to addiction.

Overall, these are highly positive results for the PRIME program in its third year. Compared to the results for the second year, the scores were higher. However, fewer 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

2023-2024 Team-Based Model Survey Results

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Sample

Surveys were distributed to all student participants in the PRIME program for the 2023-2024 academic year. A total of 29 students completed the pre-surveys, and 28 students did so for the post-surveys. 19 (65.6%) of the pre-survey participants were Social Work students, while 10 (34.5%) were Clinical Psychology students. 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.

Out of the 29 students participating in the PRIME program, 25 (86.2%) participants identified as cisgender women and four (13.8%) identified as cisgender men. 22 (75.9%) participants identified as straight, and seven (24.1%) identified as bisexual. Participants were also asked about their race and if they had Hispanic, Latino/a, or Spanish ancestry. 18 (62.1%) participants identified as White, seven (24.1%) identified as African American, one (3.4%) identified as Asian, and one (3.4%) identified as Bi- or Multiracial. Two (6.9%) participants declined to provide this information. Of the 29 participants, four (13.8%) 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?

Table 1 Demographics of Survey Respondents (N=29)

	Number of Participants	Percent
Participant Program		
Social Work	19	65.6%
Clinical Psychology	10	34.5%
Self-Identified Gender		
Cisgender Woman	25	86.2%
Cisgender Man	4	13.8%
Self-Identified Sexual Orientation		
Straight	22	75.9%
Bisexual	7	24.1%
Self-Identified Race		
White	18	62.1%
African American	7	24.1%
Asian	1	3.4%
Bi- or Multiracial	1	3.4%
No Information Provided	2	6.9%
Participant is of Hispanic, Latino/a, or Spanish ancestry		
Yes	4	13.8%
No	25	86.2%

Note: Percentages may not add up to 100% due to rounding errors.

Experiences with Team-Based Model and Significant Points

Out of the 29 students who responded to the pre-survey, only two indicated that they did not have the opportunity to participate in team-based models within their internship. These were placements that focused on individual therapy, and the respondents said that they spent most of their time on one-on-one interactions with clients. Overall, survey respondents felt extremely positive about working in a teams-based model.

Seven (24.1%) respondents discussed their experiences in team-based models, focusing on what they've learned about the importance of communication, and by extension, trust. They

understood the importance of clear and transparent communication with members of the health care team, and how this affected the quality of care they can provide. For instance, one respondent said,

> *I have learned a lot about what is effective and challenging when working with adults. The trust we have in each other's decisions when it comes to next steps for a student is crucial. Without it, there would be constant challenges and lengthy discussions. In conjunction with that, there is a need for plenty of communication on where the class of kiddos is headed next to game planning staffing to make sure all of the bases are covered. A lack of communication and buy-in to engage can make for many frustrating moments that take away from patience we need to have regarding behaviors. (SW)*

A second respondent reflected,

> *Team-based models allowed for significant learning how to properly communicate amongst colleagues. Whether it was communication regarding a client, or task that needed to be completed or that was already completed. It made it more efficient to follow up with other colleagues and staff members. (SW)*

In a similar vein, a third respondent had this to say,

> *I currently work with a treatment team consisting of other therapists, nurses, a doctor, and a case worker. I feel that I've learned how important communication is and for everyone to be on the same page. I've seen how having so many different points of view can also create more well-rounded care because other people can bring something to the table you've never thought of. (CP)*

As with other survey respondents who focused on this issue, this respondent understood the importance of clear communication with fellow team members, and also how this could affect the quality of health care delivery.

This respondent also highlighted an important issue discussed by 16 (55.2%) survey respondents. Working in a team-based model, these respondents said, brought together staff members from different backgrounds and expertise. The respondents 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, one respondent offered the following feedback:

The internship site at which I am located employs multiple counselors (LCSWs, LSWs, LPCs). These counselors operate independently for their sessions, but regularly come together as a team to address complex family systems … receive supervision and case consultation, identify ways to accomplish tasks more efficiently, and complete trainings. I think the most significant point of learning I have had is realizing I don't want to work at a location that does not utilize a team-based model, as teams keep one another accountable and serve as a source of diverse perspectives and creative solutions. (CP)

This respondent clearly appreciated the value of working in a team-based model, pointing out the ability to enhance accountability, and the ability to learn and innovate in providing health care. Several other respondents talked about what they've been able to learn from team members in other fields as well, saying:

I really enjoyed the opportunity to hear from the others in the team/group. Their input often allowed me to see things from another perspective. This will allow me to be open-minded when involved with team-based models in the future. (SW)

I appreciated the collaborative aspect and learning different perspectives from my team. I enjoyed being able to adapt to different scenarios utilizing different approaches provided to me. (CP)

Additional Questions

The majority of the students did not have any additional questions about team-based models in the pre-survey. 13 (44.8%) students provided specific questions, mostly focused on how we can better improve the efficacy of team-based models. For instance, one respondent asked how we could delegate tasks appropriately within a team-based model, while a second respondent asked how we could *"influence team members to be more productive?"* A third respondent requested *"tips for increasing engagement from other professionals,"* while a fourth respondent wondered *"how therapists may collaborate with other providers in an efficient way."* A fifth respondent asked whether there was *"any theory or research about the efficacy or optimal designs of team-based models?"* A sixth respondent provided more detail in their response, asking:

I am curious about the qualities and strategies contributing to effective team leadership within collaborative models. What leadership styles have proven most successful in fostering a positive and productive team dynamic? Conflict is an inevitable part of any team-based endeavor. I want to learn

> *more about effective conflict resolution strategies within a team setting. How can teams navigate conflicts constructively to maintain a positive and collaborative atmosphere?*

Respondents were obviously concerned about how to ensure that team-based models work well and efficiently. Generally, while they are convinced of the advantages of working within this model, they are concerned about making sure that they do so effectively. Interestingly, one respondent said in their response, *"(n)ot a question but I am interested to see how a situation would be handled if a person refuses to engage in a team-based model. How would one person in the "team" throw off the group/environment?"*

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. 28 (96.6%) 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 work with people from different specialties, and how much they've learned from their colleagues. For instance, one respondent said:

> *I have worked in many different teams in my internship this year, including group work with our volunteers, staff meetings, logistics meetings, and a fundraising committee. I have learned that it is paramount to work with professionals outside of our field to make change. I have worked alongside retired teachers from Penn Manor School District, church staff, client informants/representatives, and board members of all diverse backgrounds (finance, communications, marketing, etc.). Social workers bring an important perspective and insight to the table, but we cannot run an organization all alone. We are not experts in finance or marketing, and so we must work together to expand our mission with professionals who are knowledgeable in their own field. (SW)*

Not only did this respondent appreciate how much they were learning from colleagues in other fields, they also gained a deeper insight into the unique expertise that social workers can bring to the table. Furthermore, they gained an understanding of how difficult it can be to create lasting social change as an individual.

Another respondent also reflected on their experience working in a team-based model, saying:

> *Working with a team-based model was very much effective for me. I love the idea of integrated care and services, one of the significant points of learning was offering the client a plethora of services because each service care can impact one another. For example if a patient came into the clinic for high blood pressure, the provider might refer the patient to see a BHC on ways to reduce the high blood pressure, whether it's through smoking, eating, or stress. (SW)*

Like the prior respondent, this PRIME participant emphasized how helpful it was to learn how others can provide distinct services and health care for clients. In addition, they also emphasized, as we saw in the pre-survey, how such integrated care could be of great benefit to clients.

> *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)*

Several survey respondents said that they gained a much deeper understanding of how team-based models can provide more holistic and higher quality health care to their clients.

Finally, as with the pre-test surveys, students continued to point out the importance of communication and being on the same page with fellow team members. For instance, this respondent provided the following feedback:

> *I have learned to communicate better with other leaders. It also provided me the opportunity to learn about different cultures and agencies that provide services to my community. It also allowed me to express my thoughts and opinions. (SW)*

In addition to learning about the importance of clear communication with other team members, this respondent also learned how to improve their own communication skills. Likewise, another respondent talked about how they learned to hone their own skills and confidence level in communication, saying,

> *My internship was in Family Based Therapy, which is a team-delivered service, so I had a co-therapist in the majority of my sessions. Some significant points of learning that I had was how to lead in a session and let the other therapist lead. I also learned how to discuss difficult topics and resolve conflicts. (SW)*

Additional Questions

Eight (27.6%) students had a question about team-based models in the post-test surveys. They dealt mostly about how we can improve the dynamics of team-based models and work. For instance, one respondent asked how we can better facilitate communication between team members while another said,

> *How can behavioral health create a team in which all participants feel equally heard? Team-based models are often hierarchical (with doctors and nurses at the top), thus suppressing important voices, including those of direct care staff. (CP)*

For respondents whose questions did not focus primarily how to work more effectively in teams-based settings, one asked whether there could ever be a scenario where there are too many teams, and whether this could affect the client by giving them too many options for care. Another respondent had a question about the format in which team-based work occurred, asking,

> *Amid the COVID-19 pandemic, numerous teams have shifted to virtual operations. What relationship challenges are commonly encountered by these virtual teams, and what are recommended strategies for effectively mitigating these challenges? In contrast to traditional face-to-face teams that can employ various activities to nurture and sustain relationships, how can virtual teams navigate and overcome the obstacles to maintain strong interpersonal connections and collaboration within a remote work setting? (SW)*

Overall, the student participants in this year's PRIME cohort, even more so compared to the prior year, 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 2023 AND SPRING 2024

GOAL #4 OBJECTIVE 2

FIRST REPORT SUBMITTED MARCH 5, 2024

UPDATED REPORT SUBMITTED AUGUST 13, 2024

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 2023 and January 2024, and the second set of interviews was conducted in June 2024 and July 2024. Interviews were conducted in-person with faculty members who had not been previously interviewed over the term of the PRIME grant. For other faculty program, we requested e-mail updates (see Table 1 on the next page). In-person interviews were conducted via Zoom, and then transcribed utilizing Otter-ai software. Both faculty members granted permission for the interviews to be recorded. As with the previous year, 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.

Table 1 List of Faculty Members Embedding PRIME Topics in 2023-2024 and Who Were Interviewed For This Report

Name	Department / Courses
Andrew Bland	Psychology
	PSYC 639: Existential and Humanistic Therapies
Marc Felizzi	Social Work
	SOWK 520: Micro/Mezzo Social Work Practice
Yolanda Larson	Psychology
	PSYC 630: Applied Group Therapy
Rachel MacIntyre	Psychology
	PSYC 631: Psychotherapy and Intervention
	PSYC 636: Cognitive Therapy
	PSYC 638: Cognitive Behavior Therapies
	(new course preparation for faculty)
Heather Strohman	Social Work
	SOWK 630: Advanced Field Practicum I
	SOWK 631: Advanced Field Practicum II
Kat Walsh	Social Work
	SOWK 630: Advanced Field Practicum I
	SOWK 631: Advanced Field Practicum II
Jessica Weiss-Ford	Social Work
	SOWK 630: Advanced Field Practicum I
	SOWK 631: Advanced Field Practicum II

Key Findings and Themes From Initial Interviews

In the first round of interviews, as with last year, 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 members felt that in general, they already had fairly extensive

background in PRIME topics like cultural competency and telehealth. The PRIME trainings, they felt, had not provided them with new knowledge but rather, encouraged them to incorporate additional discussions. For instance, one faculty member said,

> *I refer my students to the PRIME trainings offered each semester. For example, I encouraged my PSYC 636 "Cognitive Therapy" course (students) to attend the PRIME training on cognitive processing therapy, as this is a topic we cover in my course. I supplemented the training with additional practical applications in my class afterwards.*

As with last year, faculty found that cultural competency was the PRIME topic that they found easiest to embed in their courses. They were also more positive about incorporating topics related to diversity and cultural competency, in contrast to telehealth. One faculty member admitted that they were still *"not sold on telehealth,"* even though they do cover it fairly extensively in their class. This faculty member felt that telehealth puts up an unnecessary barrier between the provider and client. In addition, faculty members also incorporated material focusing on teams-based practice. For instance, one faculty member offered,

> *I prepare first-year graduate students for interprofessional collaboration in the following manner. We have a semester-end assignment which asks students to attend a meeting – work meeting, staffing meeting etc. The meeting must have an interprofessional component. They must attend a meeting which includes members of various professions – nursing, medicine, psychology, law etc. They write the paper for the assignment by examining the meeting climate, the degree of interprofessional collaboration present, as well as the quality of the exchanges amongst the various professions.*

Overall, faculty felt that the addition of PRIME topics stimulated excellent discussion within the classroom.

Faculty also reported that generally, their students have responded positively to their incorporating PRIME topics into the course curricula. One faculty member said that they felt their students were particularly interested in learning more about cultural competency, to the extent that their discussions around diversity was quite organic. Not only was this topic embedded in the curriculum throughout the semester, students would also often raise this topic of their own accord. The faculty member who included a semester-end assignment on interprofessional collaboration also found that their students had generally positive responses to the assignment. They said,

> *Responses are positive, and I encourage discourse on deeper levels. Rather than "complaining" about a nurse, or a doctor in the meeting, I want students to examine the why and wherefore of the other professions' perspectives.*

However, while student responses were generally positive, one faculty member said that they really had difficulty trying to ascertain how the PRIME topics made a difference in their courses or students' responses. It could be that PRIME topics were already generally embedded within the course curriculum, or that students were already bringing high levels of enthusiasm to the course itself. Finally, one faculty member also mentioned that alongside the course, students really wished they had practical and experiential learning related to the course topic.

Finally, in terms of future modifications, faculty said that they would continue to increase discussion on cultural competency and telehealth applications, noting, however, that these were already priorities before their participation in the PRIME grant. The faculty member who designed the semester-end assignment on interprofessional collaboration offered that they would like to further encourage collaboration with professionals in other fields, particularly in Sports Psychology, Athletic Administration, medical professionals, and trainers. A second faculty member plans to invite guest speakers to their class, not only to speak on PRIME topics, but also to further focus on specific modalities, and to focus on topics like careers and licensure.

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 2023 semester, as well as the during the 2023-2024 academic year. Overall, faculty remained positive about their experiences participating in this component of the PRIME grant. Faculty also incorporated a variety of PRIME topics into their courses, including: working with impoverished clients, expressive arts therapies, interprofessional collaboration, and behavioral health interventions through trainings on postpartum depression and psychosis. All the faculty interviewed for this report also incorporated cultural competency, with one faculty member providing details on how they have done so:

> *Approaches I use to help facilitate this is: encouraging students to reflect on their own cultural identities and how they influence their worldviews, using case examples that incorporate different cultural identities, encouraging class and supervision discussions on how culture is influencing their work in role plays and direct client work, and encouraging discussions on criticisms on cognitive behavior therapy as it relates to cultural sensitivity and how to make adaptations.*

Faculty also felt that the students continued to respond well to the incorporation of PRIME topics. As one faculty member put it, this is in part due to the fact the students can see how PRIME topics are relevant not only to their field practicum, but also to their career goals, as well as the populations with whom they plan to work. Similarly, another faculty member pointed out that their students responded well to the PRIME topics in part also because *"they found it helpful to see the practical application of the theoretical material in the course in action."* This faculty member also further commented,

> *The students responded favorably, as evidenced by their level of engagement with that material, by verbal comments made in/out of class, and by statements made in their reflective journal assignments. Because (these) topics tend to be under-discussed in Psychology (not only at MU, but across the U.S.), the students seemed thirsty for them.*

Faculty also reported that they continued to think carefully about how best to incorporate PRIME topics into their courses. As with the previous year, faculty put in quite a bit of effort so that the PRIME topics are well placed within the course content. For instance, one faculty member reflected:

> *There are scaffolded assignments throughout as I provide evaluations from role plays. In supervision meetings, we review video recordings of their client work and discuss their culturally sensitive case conceptualizations and treatment plans. I also include these topics in multiple choice and short answer items on the mid-term exam, and essay questions in the final exam.*

Finally, faculty have also given some thought to how they plan to make changes and modifications in their courses and embedding PRIME topics moving forward. One faculty member offered that they would consider incorporating additional topics (e.g., behavioral health interventions) and including more of a focus on marginalized populations. A second faculty member said they planned to continue incorporating PRIME topics, and that they were also open to incorporating other topics if they were good gifts. A third faculty member contemplated how they would approach cultural competency and telehealth in future courses, saying:

> *I am always looking for ways to improve my teaching as it relates to my own cultural competency and helping students to expand on theirs. One of our new hires specializes in working with individuals with minoritized gender identities. I hope to connect with them on ways to incorporate a case example or didactic on this topic. Also, each time I reflect on these topics, I question whether and where to incorporate more discussion and didactics on using telehealth. I often prioritize other topics before this as there is so much to learn as it relates to foundational therapy skills. This is a topic that I think would fit well into an introductory course that our program has been discussing. I will also continue reflecting on how to incorporate it in my therapy courses.*

Conclusion

Overall, for this academic year, faculty involved in embedding PRIME topics into their courses had a positive experience. As with the previous year, faculty have been very thoughtful how they embed these topics, understanding that they need to help the students make connections between the theories and applications. As with the previous year, faculty also expressed some ambivalence about telehealth, and continue to find ways to best incorporate this topic.

APPENDIX I

INTEGRATING EXPERIENTIAL LEARNING EXPERIENCES INTO COURSES

FALL 2023 AND SPRING 2024

GOAL #4 OBJECTIVE 3

FIRST REPORT SUBMITTED MARCH 5, 2024

UPDATED REPORT SUBMITTED AUGUST 13, 2024

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 2023 and January 2024, and the second set of interviews was conducted in June 2024 and July 2024. For faculty who had not been previously interviewed before, we conducted in-person interviews via Zoom. For faculty who had already previously been interviewed, we followed up with a list of questions via email. In-person interviews were 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. In the third year of the grant, most (if not all) faculty had incorporated experiential learning more than once. This provided for more long-term and thoughtful reflection and assessment. We were able to interview (either in-person or via email update) most faculty members at least once during the 2023-2024 academic year, and in some cases twice (please see Tables 1 and 2 on the next page for more details).

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

Table 1 List of Faculty Members Integrating Experiential Learning Into Courses in 2023-2024 and Interviewed For This Report

Name	Department / Courses
Heather Strohman	Social Work
	SOWK 630: Advanced Field Practicum I (Fall 2023)
	SOWK 631: Advanced Field Practicum II (Spring 2024)
Kathleen Walsh	Social Work
	SOWK 631: Advanced Field Practicum II (Spring 2024)
Jessica Weiss-Ford	Social Work
	SOWK 630: Advanced Field Practicum I (Fall 2023)
	SOWK 631: Advanced Field Practicum II (Spring 2024)

Table 2 Interview Schedule With Faculty Incorporating Experiential Learning Experiences in 2023-2024 For This Report

	Late Fall 2023	Summer 2024
Heather Strohman	X	X
Kat Walsh		X
Jessica Weiss-Ford	X	X

provide recommendations on how to better support faculty members in their efforts at integrating experiential learning experiences into courses.

Key Findings and Themes From Initial Interviews

As with the previous year, in initial interviews, faculty generally had positive feedback on integrating Kognito as a form of experiential learning in their courses. Since faculty now had more experience from using Kognito, there was some trial and error in implementation, and things went more smoothly.

During the fall semester, faculty incorporation the motivational interviewing module in their courses. Faculty reported that students were generally receptive and interested in the simulation experience. One faculty member stated that they were able to discuss the applicability in the field and compare it to other theories/approaches in clinical/micro Social Work. Another faculty member had the students write a reflection essay on their experience with the simulation and make a presentation on the topic of motivational interviewing as well. Faculty reported that the students seemed more receptive to uilitization of Kognito when they can see that there is theory backing up the simulation. That way, they can then make connections between the simulations and other trainings, as well as class discussion. This syncs well with fundings from the previous year – that the Kognito simulations are best implemented with additional scaffolding, guidance, and discussion.

Interestingly, one faculty member reported that a student provided feedback concerning the content in the Motivational Interviewing module. The student focused on the issue of weight loss, and was concerned that the module adopted a "fatphobic" or "body/fat shaming" lens in the simulation. The faculty member was unclear whether they were able to provide feedback to the software company about this concern. It was also mentioned during the fall semester that Kognito would not be available for the 2024-2025 academic year, and that PRIME would be looking into utilizing new simulation software. Faculty expressed some concern about this, but still remained optimistic that experiential learning and simulations would still remain a part of the field experience seminar.

Key Findings and Themes From Follow-Up Interviews

Overall, faculty felt that the Kognito simulations still added to the students' field work experiences. Faculty felt that students responded well to the simulations, and the feedback from students was generally positive. As with the earlier interviews, it is clear that the simulations do not stand alone – faculty need to

provide scaffolding and structure around the simulations. For instance, one faculty member said that *"it worked well to do the brief Motivational Interviewing (module) collectively and facilitate discussion and allow students to do the longer versions independently."* Similarly, another faculty member said that it was helpful to *"debrief on topics and (discuss) as a group."* This faculty member also said that it was helpful to *"allow students to present cases for discussion"* in conjunction with the simulation. The value of the simulation, one faculty member felt, was that it was *"an added benefit and 'safe' practical application of new or developing skills."* Faculty members generally did not make major modifications to how they utilized the Kognito simulations.

Interestingly, one faculty member offered the feedback that *"the consensus from students was that Kognito was not great as far as simulation software goes."* Another faculty member – one who was not supervising field placement – asked about access to simulation software, and asked if they were allowed access to it. Our understanding is that Kognito is being phased out, and new simulation software will be utilized for the next academic year. Faculty members are excited to see and work with the new software.

Conclusion

In general, as with the previous year, 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. It will be interesting to compare how well faculty and students respond to the new simulation software this next academic year, compared to Kognito. While cost is probably an issue, it might be worth considering whether faculty who are not teaching field placement classes might be interested in incorporating simulation software in their classes.