Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE:
A Plan to Seek Additional Funding for 2017 /18

University of Washington's Evidence-Based Practice Institute

SUBSTITUTE SENATE BILL 5883
Section 204, (3)(a)

December 1, 2017

Behavioral Health Administration
Division of Behavioral Health and Recovery
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Transforming lives

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REPORT REQUIREMENTS

The 2017 Legislature's operating budget bill (SSB 5883), requires the University of Washington's Evidence-Based Practice Institute and the Department of Social and Health Services, Behavioral Health Administration (BHA) to develop a plan to seek private, federal, or other grant funding in order to reduce the need for state general funds. The department must submit a report to the office of financial management and the appropriate fiscal committees of the legislature by December 1st of each year of the biennium.

SSB 5883, Section 204(3)(a) states:

Section 204(3)(a): state appropriation for fiscal year 2018, state appropriation for fiscal year 2019, and federal appropriation are provided solely for the University of Washington's evidence-based practice institute which supports the identification, evaluation, and implementation of evidence-based or promising practices. The institute must work with the department to develop a plan to seek private, federal, or other grant funding in order to reduce the need for state general funds. The department must collect information from the institute on the use of these funds and submit a report to the office of financial management and the appropriate fiscal committees of the legislature by December 1st of each year of the biennium.

SUMMARY

The University of Washington's Evidence-Based Practice Institute and the Department of Social and Health Services submit the following report which: outlines the plan to seek additional, non-state funding in 2017-2018 and highlights the projects and activities currently underway, which have been funded by both state and non-state sources.

FY2017

Annual Report

Evidence-Based Practice Institute

University of Washington School of Medicine with the support of the Division of Behavioral Health and Recovery

August 2017

ACKNOWLEDGEMENTS

We are immensely grateful to the children's mental health providers, coordinators and administrators in Washington State for their guidance and collaboration. Collaborators contributing significantly to the development and products summarized in this report include Paul Davis (DBHR), Felix Rodriguez (DBHR), Rose Krebill-Prather (WSU), Michelle Mann (WSU), Haley Lowe (WSU), Russell Funk (Cascade Mental Health), Angie Ferrier (Cascade Mental Health), Amanda Gilman (WSCCR), Marna Miller (WSIPP), and all of the BHO children's care coordinators.

Evidence-Based Practice Institute Key Staff

Eric Trupin, PhD, Director
Sarah Cusworth Walker, PhD, Associate Director of Community Workforce
Jessica Leith, LMFT, Training Manager and Practice Coach
Cathea Carey, Research Coordinator
Georganna Sedlar, PhD, Clinical Assistant Professor

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Plan for Seeking Additional Funds 2017/18 and Activities in 2016/17

Part of the legislation that directs DBHR to fund the EBPI requires DBHR and EBPI to develop a plan to seek additional funds to support the institute's scope of work. In 2017/18, EBPI will seek funds to evaluate and expand programs developed with DBHR support, as follows:

Evidence Based Practice Monitoring and Validation (Reporting Guides)

1. Robert Wood Johnson Foundation *Culture of Health* ($350,000). This proposal will be submitted in March 2018 to support a validation study of therapist self-reported use of evidence-based practices using the Reporting Guides developed under EBPI. A credible method of therapist self-report will be a significant contribution to the literature on evidence-based policymaking and performance monitoring for children's mental health services.

2. National Institutes of Mental Health, Dissemination and Implementation ($500,000). This proposal will focus on the organizational and therapist-level impact of the Reporting Guides in shifting supervision and practice towards the most effective clinical elements of mental health interventions for children and youth.

Interventions for Disruptive Behavior and In-Home Mental Health Services

3. National Children's Mental Health Workforce Initiative (Substance Abuse and Mental Health Administration via the Technical Assistance Network, $75,000). This proposal will pilot test recommendations from the SAMHSA National TA Network for implementing effective in-home intensive mental health care for children and adolescents.

4. National Center for Child Health and Human Development ($325,000). This proposal will evaluate the effectiveness of a brief family intervention for improving child and adolescent disruptive behavior and engaging families in ongoing treatment.

Other Potential Funding Proposals

5. The EBPI is also discussing the Reporting Guides with the Pew/MacArthur Evidence First initiative and exploring opportunities for funding and collaboration.

6. The EBPI is also reaching out to other state-funded, university based centers to discuss potential opportunities for interdisciplinary collaborations, e.g., Alcohol and Drug Abuse Institute.

In 2016/17, EBPI sought funds through the following activities:

1. Coordination with the University of Washington Office of Advancement to seek private funding for the EBPI director role as an endowed chair ($150,000 annually).

2. Grant application with the Arnold Foundation to support a randomized trial of the MultiStystemic Therapy-Family Integrated Transitions program. The FIT program moved from evidence to research-based in the last review of the inventory. Additional investigation would

potentially move this program back to evidence-based if found to be effective in an additional trial ($400,000). While initially well-reviewed, the proposal made it to a final vetting stage but was ultimately not funded due to a shift in funding preferences to not fund research focused on improving the treatment of youth while in residential care.

The plan for additional funding will help support EBPI's current projects and other projects planned. The following sections show how the scope and breadth of the projects that EBPI has undertaken during the past year would require continued funding from state and non-state sources.

COMMUNITY WORKFORCE

***Community Workforce Director**: Sarah Cusworth Walker, PhD*

***Training Manager and Practice Coach**: Jessica Leith, LMFT*

***Key Faculty and Staff**: Eric Trupin, PhD; Cathea Carey; Georganna Sedlar, PhD; Lucy Berliner, MSW; Jason Medina MA,LMHC.*

The University of Washington's Evidence Based Practice Institute (EBPI) provides community workforce portfolio includes research, policy and direct training and technical assistance to community children's mental health providers and agencies. EBPI works closely with the Department of Social and Health Division of Behavioral Health and Recovery (DBHR) via the regional Behavioral Health Organizations (BHO) to craft policy and practice-relevant activities to support the dissemination of evidence-based practices in public mental health. The following is a short summary of our areas of focus in State Fiscal Year (FY) 2017:

- **Training and Technical Assistance.** EBPI supports a menu of learning communities and direct clinical training to support evidence-based practices. These training products are developed and refined annually after receiving input from BHOs and providers through a statewide needs assessment survey and discussion of results. In FY17, EBPI trained 100 community workforce providers.

- **Policy.** EBPI partners with DBHR to develop policy solutions to translational challenges. Over the past two years, EBPI has focused on developing a Reporting Guide to assist providers in accurately reporting and documenting the use of evidence-based practices. Additionally, EBPI worked closely with DBHR to identify the formulas for monitoring EBP use through billing reports received from contracted provider agencies. In FY17, EBPI also began a pilot project with Cascade Mental Health in Centralia to develop a monthly tracking system for using evidence-based practices and performance metrics in line with the recommendations of the Reporting Guides.

- **Research.** EBPI also collaborates with DBHR and other partners to conduct research on topics that will forward the use of EBP in public mental health settings. In FY17 this includes a collaboration with the Washington State University Social Sciences and Economics Research Institute and DBHR to explore the associations between client satisfaction and improved clinical outcomes. EBPI also conducted a number of literature reviews on topics of interest including performance monitoring, benchmarks for EBP penetration in public systems, and the essential elements of effective clinical practice in children's mental health.

In State Fiscal Year (FY) 17, an annual needs assessment with a menu of training options was distributed in to each Behavioral Health Organization, of which 8 chose to participate. This document reviews the results of the evaluations from each training provided by EBPI, and has informed the offerings currently being provided in FY17.

TECHNICAL ASSISTANCE AND TRAINING

SUMMARY OF ACTIVITIES:

EBPI offers clinical training and technical assistance to support the implementation of EBPs to community mental health agencies by collaborating with each regional behavioral health organization in WA State. EBPI's training portfolio is informed by an annual needs assessment that is distributed to BHOs and provider agencies who provide feedback into which training options they are most interested in as well as any new content that they would like to receive. EBPI's technical assistance and training portfolio comprises a number of planning and direct service activities. A summary of these activities is summarized below, followed by more detailed descriptions of each product and activity:

- Conducted joint training plans with each BHO region:
    - Coordinated with each BHO child care coordinator to inform them of the needs assessment survey and to set up a call to review the results
    - Prepared 10 needs assessment reports for each BHO region
    - Conducted one hour calls for each BHO (10) to review the annual needs assessment data and begin training planning for their region
- Attended BHO child care coordinator quarterly meetings:
    - Attended 4 quarterly BHO child care coordinator meetings to present EBP reporting guides and gather feedback, including reviewing EBP SERI code reporting methods and percentages
- Coordinated trainings in each region:

    - Coordinated with BHO child care coordinators to identify a training venue, number of participants, and to answer additional questions.
    - Developed marketing materials and distributed training information to each BHO and participating community mental health agencies
    - Engaged in direct outreach to community mental health agencies clinical directors to discuss the training and identify potential participants
    - Developed a training registration database
    - Distributed reminder emails of training information to stakeholders and participants
- Developed and improved existing training options:
    - Assessed the impact and value of the previous year's training content and revised content to respond to initial feedback in post-training evaluations (2 trainings)
    - Developed a new training (STAY: Slow down/Take Interest/Assess your role/Yield to another perspective), including literature research, meetings with developers, manual development, QA structure, and handouts (approximately 700 hours)
- Delivered 3 trainings across the state (Engagement, Working with Families in Crisis, STAY)
    - Conducted 60 hours of consultation calls following trainings
- Evaluated trainings with satisfaction and knowledge assessments.
    - Developed pre-training survey case vignettes for 3 trainings
    - Developed an online database to track pre and post training data
    - Analyzed data for reporting back to BHOs and for the annual report

TRAINING

EBPI offers clinical training and technical assistance to support the implementation of EBPs to community mental health agencies by collaborating with each regional behavioral health organization in WA State. EBPI's training portfolio is informed by an annual needs assessment that is distributed to BHOs and provider agencies who provide feedback into which training options they are most interested in as well as any new content that they would like to receive. A detailed description of each of these offerings is listed below:

ENGAGING FAMILIES IN CHILDREN'S MENTAL HEALTH TREATMENT

A 3 part training over 5 sessions that address common barriers to engaging clients utilizing evidence based engagement techniques. Direct service providers and their supervisors learn about some of the logistical and perceptual barriers to successful engagement. They also learn strategies for addressing these barriers, and ongoing consultation to promote adoption of these skills. EBPI delivers the training as a consultation series in a learning collaborative format.

1. **PRE-TRAINING WEBINAR.** A one hour webinar which provides a basic overview of some of the most common barriers to client engagement in or completion of mental health

treatment. Participants will be able to identify individual, organizational, and system level influences which contribute to lack of engagement in children's mental health treatment.

2. **LIVE TRAINING.** A live, 3 hour training which provides evidence based techniques and strategies for successful engagement to clients and their families in children's mental health treatment. Participants have the opportunity to engage in role-play and group discussion.
3. **CONSULTATION.** Participants will complete three consultation calls, which generally begin 2-3 weeks upon completion of the live training. These calls will provide support from the trainer for ongoing implementation of the engagement strategies learned in the live training.

IMPLEMENTING EBPS WITH FAMILIES FACING ADVERSITY AND CRISIS

A consultation series that helps clinicians to stay on track with treatment when using EBPs with families who are facing numerous stressors and crises that could derail treatment. This consultation provides direction in ensuring that families in community mental health are able to receive support for both short term and chronic stressors without disruption in their treatment plan. Direct service providers and their supervisors gain an overview about the impact of exposure to violence, poverty and stressors on families' participation in EBPs, and ways to overcome these challenges when using EBPs. The majority of this series is direct discussion of cases and applying strategies to participant's clinical experiences and current cases.

The training series is a combination of didactic learning and clinical case application in a learning collaborative format*:*

1. **INITIAL WEBINAR**. A one-hour didactic webinar conducted during an initial consultation call and which provides an overview of best practices for using EBPs, sticking to clinical targets, and practical strategies for keeping on track with EBPs
2. **CONSULTATION CALLS.** 3 subsequent consults calls will involve case discussion and case presentations in in order to directly apply material learned in the webinar to clinicians' current practice. It is expected that participants will present their cases for discussion during the calls.

STAY

"Slow down, Take interest, Assess your role, Yield to another perspective"

STAY is a brief intervention for families with adolescents experiencing mild disruptive behaviors. The STAY model uses a hybrid of evidence-based strategies and techniques that include parent management interventions and components of cognitive behavioral therapy which are delivered

through a multi-step approach over the course of 4 sessions. At the conclusion of the 4 sessions, guidance is provided as to how to transition a family into an extended treatment, if needed.

The 4 Basic Principles of STAY encourage the family to:

1. **S**low down
2. **T**ake interest
3. **A**ssess your role
4. **Y**ield to someone else's perspective

These are accomplished by using a problem-solving framework with families, which includes **engagement, emotion regulation, cognition building, and parenting strategies**. Therapists are given guidance as to when it is appropriate to move to the next stage with their families with measured objectives and progress monitoring. STAY was designed to offer a systematic approach for therapists to adhere to while remaining flexible to meet the needs of their diverse families and youth.

Training consists of one live in person training that is delivered over the course of a full day. Participants are also required to participate in 12 follow up consultation calls by the trainers. There will also be a quality assurance process that is still being developed at this time.

TRAINING PARTICIPATION

In FY16, EBPI offered three different training topics over the course of 8 training dates. There was participation from 8 BHOs representing 48 community mental health agencies with a total of 114 participants in the trainings.

Two of these trainings were offered again in FY17, with the addition of a new training (STAY) that was piloted at a multisite agency in Yakima. The STAY intervention was developed by EBPI after the results of the FY16 needs assessment indicated a gap in treatment availability for families with adolescents experiencing disruptive behaviors.

For FY 17, EBPI reached out to each BHO to share results of the provider feedback for their region and to offer the menu of trainings. As a result, trainings were implemented within 5 BHO regions with the remaining regions delaying or declining training. Two BHOs indicated that they needed to prioritize Wraparound with Intensive Services (WISe) implementation in order to meet state requirements for this, and did not have the capacity to host our trainings in their region. A third BHO was interested in bringing the training, but asked to delay until fall 2017. One region reported that they would prioritize training on the EBP Reporting guides and a 5th region is an early adopter RSA and not part of the BHO network.

Figure 1: 2016-17 Map of Technical Assistance Trainings at the county level by BHO

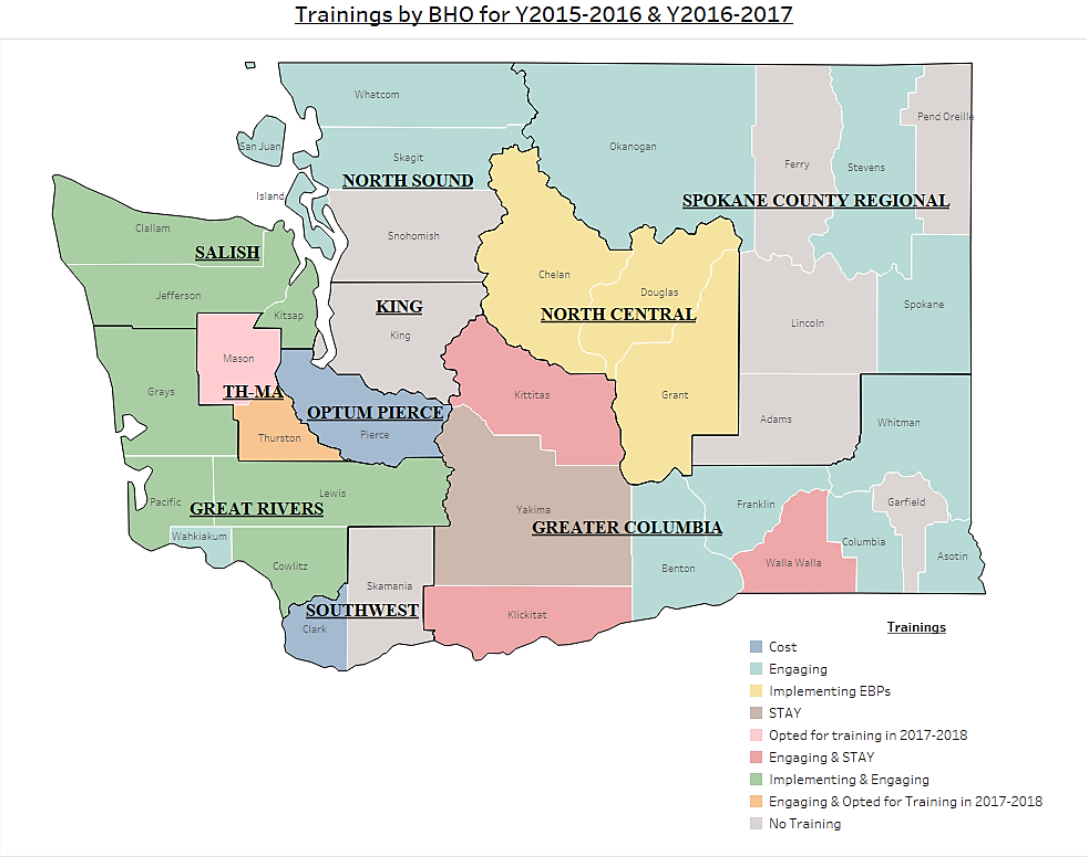

Figure 2: 2016 Map of Technical Assistance Trainings at the county level by BHO

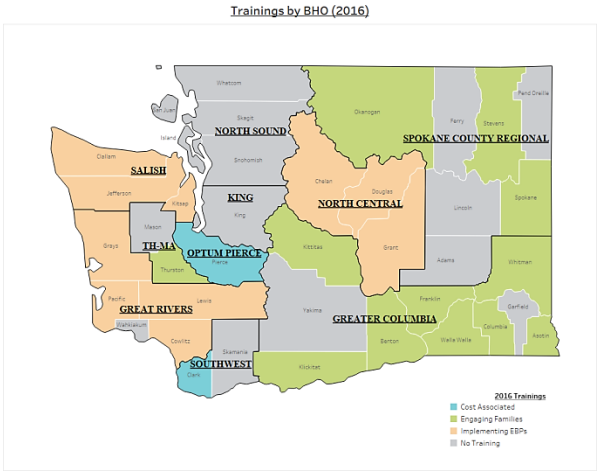

Figure 3: 2017 Map of Technical Assistance Trainings at the county level by BHO

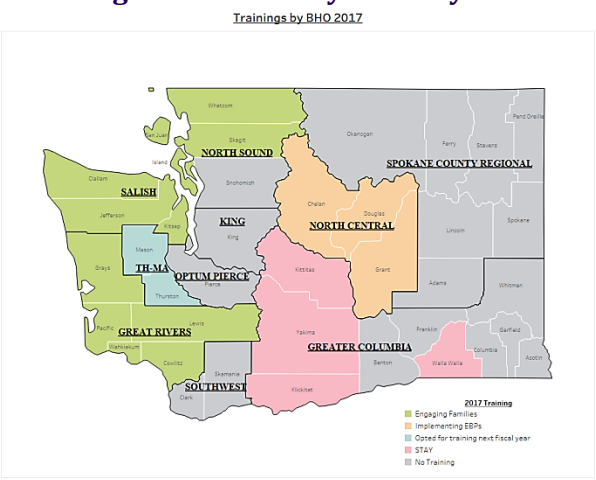

Table 1: 2016 Technical Assistance and Training Metrics

Training	BHOs	Attendees	Provider Sites	CEUs provided
Engaging Families in Children's Mental Health Treatment		**75**	**26**	**61**
	Thurston/Mason	20	4	19
	Greater Columbia	24	8	18
	Spokane	31	14	24
Implementing EBPs with Families Facing Adversity and Crisis		**30**	**15**	**9**
	Great Rivers	12	6	4
	North Central	7	5	3
	Salish	11	4	2
Cost Associated with Implementing Research and Evidence Based Practices for Children and Youth		**9**	**7**	*Not offered
	Southwest RSA	5	4	
	Optum/Pierce	4	3	
Total		**114**	**48**	**70**

Table 2: 2017 Technical Assistance and Training Metrics

Training	BHOs	Registrants	Attendees	Provider Sites
Engaging Families in Children's Mental Health Treatment	Great Rivers	8	6	Sea Mar Community Health Center, Catholic Community Services, Columbia Wellness, Cascade Mental Health Care, and Great Rivers BHO
	Salish	16	14	Kitsap Mental Health Services, Discovery Behavioral Health, Peninsula Behavioral Health, West End Outreach Services, and Salish BHO
	North Sound[1]	25	20	Compass Health

TOTAL Engagement		**49**	**40**	
Implementing EBPs with Families Facing Adversity and Crisis	North Central	19	11*	Grant Integrated Services, Columbia Valley Community Health, Children's Home Society of Washington, and Catholic Family & Child Services
Treating Adolescent Disruptive Behavior (STAY)	Greater Columbia	32	29	Comprehensive Health Care *Ellensburg, Goldendale, White Salmon, Yakima, Walla Walla, and Sunnyside*
Outcomes monitoring pilot sites	Great Rivers		Agency-wide	Cascade Mental Health Care
Total		**100**	**80**	

** Due to low response rate to training*

TRAINING EVALUATION

Engaging Families. We received a total of 30 responses to the post training surveys out of 40 who participated in the Engaging Families in Children's Mental Health Treatment training consultation series. Participants were asked to rate the usefulness of each part of the series, including the pre-training webinar, live in-person training, and the three follow up consultation calls. All areas of the training and consultation were rated as helpful. Responses indicated that participants enjoyed the live training the most, with an average response of 4.5 on a scale of 1 to 5, with 1 being not helpful and 5 being very helpful. Material (4.2) used in the training as well as the activities and discussions (4.2) were also rated as helpful to very helpful. The pre-training webinar, which covered more basic introductory information, was not rated as helpful (3.9) as the live training follow-up consultation calls, in which participants directly applied the training skills to current cases.

Responses from open-ended questions supported the high satisfaction for the live training. For the live training, participants had overwhelmingly positive feedback about the usefulness of the training, with nearly every comment reporting that the case discussions and ability to problem solve in the training as most helpful. Recommendations included adding more time to review and interact. The consultation calls seemed to be a positive experience for those who were able to participate, with many appreciating the ability to consult with their peers about their cases. Participants would have liked to have had more case presentations from their peers on the calls and more targeted topics around common engagement themes to use as discussion when time allowed.

Participants who had completed the trainings and but did not complete the consultation calls were recruited to participate in 15 minute follow-up interviews (n = 4), with results listed in Table 6.

Table 3: Post Training Evaluation for "Engaging Families in Children's Mental Health Treatment"

Questions	N*	Mean	Qualitative Examples
How useful was this pre-training webinar?	30	3.90	The pre-training webinar brought up issues for consideration. This helped to form better questions and input during the training
How was the presentation of topics?	30	4.33	The case discussions and problem solving strategies were really helpful

How were the handouts and print material?	30	4.20	I really enjoyed and have posted the handout on Engagement/Motivational Enhancement. I also posted the Stage of Change handout in my cubicle.
How were the activities and discussions?	30	4.20	The group discussion was very good. Being able to discuss cases and how to use training
How helpful was the in-person training?	28**	4.50	The trainer reaffirmed the positive strategies we are already implementing and helped our staff problem-solve new ways of engaging families.
How helpful were the consultation calls?	27**	3.56	It was helpful to get insight for current cases with ways to strengthen families who had been difficult to engage

Scale ranges from 1 (Not Helpful), 3 (Neutral), to 5(Very Helpful)
**N reflects the number of those who chose to complete the post training survey*
***Represents the number of those who chose to answer the question.*

Implementing EBPS with Crises. We received 4 responses (Table 4) to the post training survey for the Implementing EBPs with Families in Crisis training consultation series. Overall participants rated the training as fair when asked about the quality of the training (2.75) and presentation of topics (2.75) on a scale of 1 to 5 with 1 being very poor and 5 being very good. The material (3.25) and activities and discussion (3.25) were rated highest, however average responses indicated that participants were only somewhat likely to apply the skills learned in the series to their current cases (2.3). Qualitative responses indicated that there was some confusion and misunderstanding as to the expectations of the training and the content presented. Many were under the impression that it was going to cover more specifics around which EBPs to use with certain families, rather than how to stay on target with EBPs when working with families in chronic crisis.

Participants who had completed the trainings and not completed all of the consultation calls were recruited to participate in 15 minute follow-up interviews (n = 1). These results are listed in Table 7.

Table 4: Post Training Evaluation for "Implementing EBPs with Families Experience Adversity and Crisis"

Questions	N*	Mean	Std. Dev.	Variance
What was the overall quality of this training?	4	2.75	0.83	0.69

How was the presentation of topics?	4	2.75	0.83	0.69
How were the handouts and print material?	4	3.25	0.83	0.69
How were the activities and discussions?	4	3.25	0.83	0.69
What was the overall quality of this training?	4	2.75	0.83	0.69

Scale ranges from 1 (Not Likely) to 4 (Very Likely)

**N is the number of those who chose to participate in the follow up training survey*

STAY. Participants were asked to rate the quality, presentation of topics, material, activities/discussions, and overall helpfulness of the STAY training. Responses indicated high satisfaction, with each question earning 4.33 to 4.57 on a scale of 1 to 5, 1 being very poor and 5 very good. Participants were also asked to write in which aspects of the live training were most helpful, with many reporting satisfaction with the experiential nature of the training and use of role play and discussion. Apart from the actual training, some responses referred to the clear layout and flow of the intervention, especially its focus on incorporating the entire family and having useful strategies to use with them. Recommendations for improving the training included increasing the time to deliver the training and including live demonstration and/or videos of the skills being taught.

Table 5: Post Training Evaluation for "STAY"

Questions	N*	Mean	Qualitative Example
What was the overall quality of this training?	24	4.42	I liked the inclusion of Dan Siegel's material, and the emphasis on the importance of family involvement. The presenters were personable and reasonably skilled.
How was the presentation of topics?	24	4.46	Good organization/Flow of intervention
How were the handouts and print material?	24	4.42	I like the manual. I was able to imagine how sessions would look, more so than during trainings of other EBPs trainings
How were the activities and discussions?	24	4.33	I liked role playing different aspects to more fully understand model

How helpful was this live training?	24	4.57	This seems really useful. I like having something to help families with communication skills. I like that it incorporates families the whole time

Scale ranges from 1 (Not Helpful), 3 (Neutral), to 5(Very Helpful)

**N represents the number of participants who chose to complete the post training survey*

KEY INFORMANT/PROVIDER CALLS

Key informant calls were initiated by EBPI staff following the conclusion of the trainings and consultation calls. The objective of the calls was to gather feedback from participants who were unable to participate in some or all of the consultation calls, as well as more in depth feedback about the efficacy of the training. At least one participant was selected from each training and from each BHO. Potential participants were contacted via email by EBPI research staff and asked to participate in a voluntary follow up call with pre-selected questions. Participants were given a $15 Starbucks gift card as an incentive for taking the time to interview with our staff. Responses were transcribed by the interviewer and for the purposes of this report we have abbreviated the qualitative feedback taking into account the different themes which arose.

Table 6: 2016-17 Key Informant Metrics

Training	Total Participants*	Number of Participants recruited for key informant calls	Number of Participants who completed the calls
2016 Engaging Families in Children's Mental Health Treatment	77	3	3
2016 Implementing EBPs with Families Facing Adversity and Crisis	41	2	1
2017 Engaging Families in Children's Mental Health Treatment	49	7	4
2017 Implementing EBPs with Families Facing Adversity and Crisis	18	3	1

**Represents the total number of registered participants, not those who completed the entire series.*

Engaging Families. A total of 4 people were interviewed from the Engaging Families in Children's Mental Health Treatment training, after attempting to engage with a total of 7. When asked about some of the barriers to participating in the calls, many reported that it can be difficult to attend the calls when they also have to be present for their clients, and this was especially so for those working on WISe teams. Participants cited the mandatory nature of the calls as to why they did participate, as well as the opportunity to connect with their peers and get some extra tips for engaging their clients.

Participants were also asked to identify what they perceived as strengths of the calls, as well as opportunities for improvement. Similar to the feedback in the training surveys, participants noted the importance of being reassured that they are "on the right track" with their current engagement techniques as well as being able to learn from their peers and the ability to gather some additional tips for engaging clients. In terms of how we might encourage others to participate in the calls in the future, responses suggested identifying times in the live training and ensuring that it is appropriate to participate (e.g. supervisors who attend training but don't see clients).

Implementing EBPS with Crises. EBPI staff reached out to a total of 3 people who participated in the Implementing EBPs with Families Facing Adversity and Crisis training, and one (1) agreed to be interviewed. This respondent indicated that there was some confusion over how to sign up for the training as well as scheduling conflicts at their organization. They appreciated the reminders for the calls from the trainer, and the ability to space them out so that they were not back to back. Feedback around how to improve the training was consistent with the training evaluation feedback, indicating a misperception as to the content of the training.

RESEARCH

EBPI conducts research on topics to advance the use of evidence-based practice in public mental health settings. In FY17, EBPI focused research efforts on a collaboration with DBHR and the Washington State University Social and Economic Sciences Research Center (SESRC) to examine the associations between client feedback and post-treatment outcomes. The research was conducted to inform EBPI's pilot of agency-level performance measures for evidence-based reporting. EBPI also collaborated with the Washington State Center for Court Research (WSCCR) to conduct an evaluation of a child to parent violence program (Step Up) as part of the scope of work to support evaluation of promising programs on the Washington State Inventory of Evidence, Research-based and Promising Programs. A summary of these activities is outlined below with more detailed descriptions of products and activities following:

- Collaborated with DBHR and WSU to conduct research on client outcomes:
    - Drafted a research summary for DBHR review
    - Submitted human subjects /Institutional Review Board (IRB) application

  - Traveled to Pullman, WA for an in person meeting with WSU to discuss research strategy
  - Phone meetings to discuss analysis and results
- Collaborated with WSCCR to conduct research on a promising child to family violence intervention program (Step Up):
  - Drafted a research summary for review with the Community Juvenile Justice Accountability Act workgroup.
  - Submitted human subjects/IRB application
  - Requested and obtained data from the Washington State Center for Court Research.
  - Collaborated with WSCCR on research strategy and design.
  - Conducted weekly calls to review progress.
  - Drafted summary report of results.

CLIENT FEEDBACK AND OUTCOMES

Client feedback is a broad term that encompasses various types of client reporting on the quality of healthcare services. It is a common expectation of quality of care as indicated by its inclusion on one of the most widely used frameworks for quality healthcare measurement (Donabedian framework, ref). At the same time, research on the relationship between client feedback and health outcomes is mixed, with some studies showing a negative relationship between client satisfaction and improvement (ref). Apart from its potential or problematic value as a point of performance measurement, client engagement and feedback is also increasingly seen as clinical best practice. The consumer based movement in mental health highlights this importance; consequently, collecting routine client feedback has its own value distinguishable from the potentially direct relationship with outcomes.

EBPI took steps to better understand this relationship in collaboration with DBHR and SESRC. The WSU center is subcontracted by DBHR to conduct annual client satisfaction surveys with random samples of youth and adult mental health Medicaid users in Washington State. The study is still in progress and results are expected to be reported by December 2017.

STEP UP EVALUATION

Step Up is a 21 week, parent and youth group intervention for families for which a youth is being consistently violent (verbally or physically) in the home. The central therapeutic concept in the program is the abuse and respect wheels which reinforce a positive approach to conflict resolution along with cognitive restructuring, problem-solving and motivational approaches. The overarching philosophy of the program is restorative in which the youth is encouraged to recognize the effects of their actions on others and repair harm. The program is appropriate for

youth ages 14-17 and both male and female youth. Families from diverse backgrounds have participated in Step Up (African American, East African, Latino, Caucasian-non Latino, Native American, and Asian).

The evaluation is being conducted in collaboration with the Washington State Center for Court Research, the research arm of the Administrative Office of the Courts. The results will shortly be released.

POLICY

EBPI works closely under the direction of DBHR to propose and evaluate policy solutions to challenges facing EBP implementation at the state level. Over the last two years, EBPI and DBHR have focused on developing clear guidelines for EBP reporting as well as appropriate monitoring and counting of EBPs from the state billing database. These activities fall under three areas:

- **Promising practices review.** EBPI conducts an annual review of promising practices for inclusion on the Washington State Inventory of Research, Evidence-Based and Promising Programs.
    - Advertising Inventory Update
        - 2 hours emailing inventory update announcements to 2536stakeholder listserv (includes BHO care coordinators, DBHR, community mental health agencies, child welfare, and juvenile justice stakeholders).
    - Monitor submissions
        - 5 hours responding to applicant questions, gathering appropriate application materials, and organizing information.
    - Reviewing applications
        - 40 hours reviewing applications, submitting eligible programs to WSIPP for review, and collaborating with WSIPP on final determinations.

Table 7: 2017 Promising Practice Applicants

Program Name	Category
Circle of Security Parenting	*General Prevention*
Acceptance and Commitment Therapy (ACT)	*Mental Health (Treatment Organization Approach)*
Marijuana Education Initiative	*Substance Abuse*
MyJOB	*Juvenile Justice*
Family Treatment Courts	*Juvenile Justice*

- **The Reporting Guides** provide written direction to providers for when it is appropriate to report an EBP for mental health services. It employs a research grounded and innovative approach to monitoring EBPs for state level reporting by directing providers to use the essential elements of clinical treatment types as the basis for documentation rather than fidelity to name brand treatment programs.
    - Developed an animated web-based training video on how to use the guides to support state level dissemination. The training video is available online at https://www.youtube.com/watch?v=SvQcAWM6TtA&feature=youtu.be
    - Shared with DBHR and clinical consultants to obtain initial feedback from partners and stakeholders, revising script and content, and re-record.
    - Shared with WSU for posting on the WSU Workforce training site.
    - Develop a knowledge quiz to assess impact.
    - Presented on the Reporting Guides and EBPs at the DBHR WISe Symposium
    - Facilitated a workgroup at Cascade Mental Health to co-develop a monthly EBP and performance monitoring structure with biweekly meetings from May 2017 through August 2017 (continuing into FY17/18 scope of work).

- **Calculating EBP rates** is a project focusing on how to clean and calculate reported EBPs when provided via billing codes in the Washington State Provide One system, using the codes outlined in the Service Encounter Reporting Instructions (SERI).
    - Participated in routine meetings with DBHR research management to discuss developing the formula for calculating an EBP rate.
    - Received preliminary EBP reporting data from DBHR and calculated error rates per BHO and presented the data at a BHO quarterly guide for discussion.
    - Finalized the guidance for EBP reporting and calculations with DBHR.
    - Instituted the guidance in the Reporting Guides.
    - After receiving 2016/17 data from DBHR, used the formula to calculate the EBP rate for the annual report.

REPORTING GUIDES

Developing the Reporting Guides (with the most recent version due September 2017), involved coordination with the Washington State Institute for Public Policy, the BHOs and direct service providers, literature reviews on meta-analytic results of treatment category types as well as previous and current efforts to translate what are known as “common elements” into policy-relevant practice.

Determining the clinical elements. EBPI accessed two primary sources for determining the essential and allowable elements of evidence-based children's mental health treatment: Distillation and Matching model organizing frameworks and WSIPP meta-analyses of treatment categories. Using the common elements as defined by the Practice Wise Distillation and Matching model, EBPI developed a working cut off for determining which of the common clinical elements would be considered "essential." These are elements that define and distinguish the treatment approach from other approaches, and which appear to be empirically essential to achieving positive treatment outcomes. These common elements were then reviewed by clinical experts in children's mental health through the EBPI network to further refine and determine the elements (achieved through consensus).

Determining required training and consultation. EBPI reviewed the extant training and consultation literature to assess how to establish the minimally required support for being able to report the use of an EBP. One of the challenges facing EBP implementation at a state level is that the EBP programs may not have training and Quality Assurance (QA) infrastructure and, if not provided in some manner by the state, it is unclear whether the outcomes demonstrated in research would hold for implementation under real world circumstances (e.g., providers self-train through manuals, DVDs or online). The research on training to date suggests live training with feedback about competency provides a reasonable, conservative approach to increasing the likelihood that providers have a basic understanding of and ability to provide the treatment. Similarly, the literature suggests that consultation may be even more important than training in bolstering clinical quality; however, other EBPs have achieved positive effects in effectiveness trials with minimal ongoing consultation. Consequently, EBPI defaults to the consultation expectations of the reported EBP. When reporting a generic treatment category, the Reporting Guides do not require ongoing consultation apart from routine clinical supervision; however, the Guides do require that treatment plans and progress notes document the use of evidence based clinical elements in a fairly precise manner.

Clinical Documentation. The goal of clinical documentation is twofold. The first purpose of documentation is to ensure that, when reporting the use of an EBP, the provider is aware of the essential clinical elements of the treatment practice. While documentation does not ensure quality implementation, it demonstrates awareness and intent to adhere to the aims of the treatment approach. The second purpose of clinical documentation is to minimize paperwork by aligning the documentation of EBP into already required documentation activities and to, additionally, provide support for quality documentation, generally, of clinical mental health practice.

Roll out. The Reporting Guides are now the standard for EBP reporting as indicated in the FY17/18 BHO contracts for EBP reporting from DBHR. EBPI has developed a web video explaining how to use the guides and will conduct up to 10 workshops in the following year to provide regional and onsite support for how to use the guides to document EBP practice. This roll out will be evaluated to assess the impact of the Reporting Guides on how EBPs are perceived in the public

mental health field and whether the Guides can be feasibly used by providers and supervisors with minimal training and external support.

CALCULATING EBP RATES

The next step after determining the requirements for EBP reporting was to ensure that the calculation of EBP rates was accurately assessing the intent of performance monitoring. The determination of a minimum rate was first addressed in early drafts of Engrossed Second Substitute House Bill 2536 (2012), which directed the three child serving state departments to substantially increase the use of EBPs in funded services. A specific rate, however, did not last in the final bill as no baseline had been established for any of the departments' use of EBP at this time. Consequently, the bill directed the three agencies to "substantially increase" the use of EBPs over the following three years. Currently, DBHR enforces the intent of this bill and its associated statute, RCW 43.20C.020, with a contracted minimum rate of EBPs. For mental health outpatient services, regional BHOs are expected to meet the EBP benchmark of 30% for 2017.

EBPI worked in close collaboration with DBHR to develop a reasonable approach to calculating this rate given the diversity of mental health services billed in outpatient services and the intent of the EBP requirements. The rate is calculated using two components. The first is the count of eligible services operationally defined as encounters that comprise at least 30 minutes of individual, group and family psychotherapy. Eligible services are identified by 10 specific Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes in the Reporting Guide, and do not include case management services and Wraparound. The total count of eligible services, or encounters, regardless of whether a R/EBP is reported or not, is used as the denominator *B* in the formula below. The second component consists of eligible services where correct R/EBPs are reported. Correct R/EBPs were identified from the WSIPP inventory as having demonstrable clinical outcomes for specific mental health disorders. They do not include R/EBPs for program areas such as substance abuse, child welfare and juvenile justice. The count of eligible services with correct R/EBPs is the numerator *A*. A preliminary analysis of outpatient youth mental health service encounter data revealed issues in data reporting and completeness preventing the application of the formula for this report. Once those issues have been addressed, the formula will be applied in calculating the percentage of eligible service encounters with corrected R/EBP.

A = Eligible services with corrected R/EBP

B = Total count of all eligible services (identified by 10 CPT/HCPCS codes)

Rate = A/B*100

UNIVERSITY WORKFORCE

BACKGROUND

***University Workforce Director**: Eric Trupin, PhD*

***Key Faculty and Staff**: Georganna Sedlar, PhD; Jessica Leith, LMFT; Cathea Carey; Terry Lee, MD., Joshua Leblang, LMHC*

The University of Washington's Evidence Based Practice Institute (UW EBPI) developed a university based Workforce Initiative in 2009 to address a gap between student interest in providing EBPs and availability of children's mental health training to use those practices. The development of an empirically supported foundation of programs and practices with new and existing direct service providers was supported by HB 1088 and subsequently E2SHB 2536/RCW 43.20C.020.

The initial objective of the University Workforce Initiative focused on graduate students from interdisciplinary programs at the University of Washington through graduate courses and a monthly lecture series. It has subsequently expanded to include an inter-university taskforce focused on disseminating evidence-based practices in multiple venues of mental healthcare advanced training.

- **Graduate courses** have been conducted quarterly and in person on UW's campus. Kerns et al. (2016) found that graduate students (n=137) overall showed an increase in self-efficacy across all three (3) courses, Parenting Interventions(Parenting Management), Anxiety/Trauma Treatment(Trauma Focused Cognitive Behavioral Therapy), and Extreme and Complex needs (Extreme And Complex Behaviors).
    - **Graduate Courses**
        - Coordinate graduate courses each quarter with the psychology department to assign room, identify instructors, and complete administrative paperwork.
        - Develop and maintain an online database for each course that students can use to access course information, assignments, and grades.
        - Communicate with students registered for the class throughout the course.
        - Develop and revise material for each (three total) course, for a total of 9 credit hours (three hours a week for three quarters).
        - Conduct one graduate course in fall, one in winter, and one in spring quarters.
        - Facilitate pre and post graduate course surveys to students to assess skill acquisition
        - Analyze student data from pre and post surveys and develop results into charts and tables to report to DSHS/DBHR quarterly and annually.
        - Develop and distribute materials for students.

- **EBP Certificate Program**
  - Explored the feasibility of creating a certificate program in EBPs by engaging with the graduate school and UW Continuum College to determine which entity would be interested in pursuing this.
    - Coordinated and conducting meetings to discuss the logistics of each option.
    - Completed appropriate paperwork for the graduate school and facilitated the development of a faculty taskforce as required.
    - Transitioned the EBP Certificate program to the UWCC as recommended by the graduate school and coordinated/conducted meetings with faculty and staff to gather information.
    - Supported UWCC to develop a marketing research survey to distribute to potential employers and students as part of the certificate development.
    - Communicated with UWCC staff to answer questions and supply information as requested.
    - Developed a proposal for a EBP Certificate program through the UWCC.
    - Developed a budget and revised as needed to submit to UWCC leadership.

- **The lecture serie**s was held in the School of Social work auditorium. As awareness of EBPs grew at the academic level, the audience evolved to include more community level providers. After consulting with DBHR, who was interested in reaching other providers throughout the state, EBPI established a web based format as the primary method of delivery for the lecture series beginning in 2016. Overall, Kerns et al. (2016) found that of the 561 participants who attended a lecture between November 2009 and May 2014, 97% percent rated the lecture highly, with a rating of 5 or higher on an 8-point scale.
  - Research and identify workforce lecture topics for the year (six total).
  - Schedule workforce lectures, develop marketing materials and distribute to statewide listservs, and set up web video lectures via online web based engine (Zoom).
  - Communicate with participants and lecturers to answer questions and ensure information is appropriately disseminated.
  - Facilitate each workforce lecture on the day of.
  - Distribute surveys for each workforce lecture and analyze data, compiling results into tables and charts.
  - Coordinate with the National Association of Social Workers WA State division to gather and distribute CEU's for eligible participants.

- **The inter-university EBP taskforce** was a new initiative in FY17 inclusive of ten different colleges and universities in Washington State to discuss opportunities to integrate evidence-based practice principles into professional training.
    - Communicate with and solicit information on EBPs in curriculum from interdisciplinary programs throughout the State (Bastyr, Antioch, City University, and Eastern Washington University) who had not responded to the survey conducted in FY16.
    - Coordinated the development of the taskforce by engaging with stakeholders from universities and colleges in WA State, which included participation from 10 schools in addition to interdisciplinary faculty from UW (psychiatry, psychology, social work, nursing, school psychology, and public health).
    - Developed a charter and action plan for the Inter-university EBP Initiative.
    - Coordinate and conduct quarterly taskforce meetings.

EBPI has been collecting data for the graduate courses and lecture series since 2009, and has included them annually in reports to the State. Data for the courses have included student's department, major, and skill level pre and post. Similar data were collected for the lecture series, including information on participant's job titles, department affiliation (if applicable), interest in CEU's, and general satisfaction questions with a write in comment option. With the transition to the webinar format in 2016, this information expanded to include BHO affiliation, state, and postal codes. This report includes an overview of the data results for the three graduate courses and lecture series which took place in FY17.

GRADUATE COURSE IN EVIDENCE-BASED PRACTICES

The EBPI conducts three graduate courses to address the need for a workforce trained to deliver EBPs. The courses are interdisciplinary and can be taken by graduate students to complement their current field of study (e.g., social work, school psychology, etc.). These courses prepare graduate students in service fields to provide and support evidence based practices (EBPs) for children's mental health when they graduate. Detailed explanations of the courses can be found below.

EVIDENCE-BASED PRACTICE CERTIFICATE PROGRAM

EBPI has collaborated with the UW Continuum College to determine the feasibility of developing a Certificate Program for Evidence Based Practice in Children's Mental Health. The UW Continuum College is currently conducting a market research study to gather perspectives from potential applicants and employers in the field as to the benefit and interest of such a certificate. The survey is expected to be completed in August 2017 with a formal determination as to whether or not to proceed with developing the program at that time.

If approved, the certificate would be structured for individuals whose professional work would primarily serve children and families, and who want to enhance their current skill set by learning hands on about specific evidence based practices that target commonly occurring behavioral health problems.

At the completion of the Certificate program, students will be able to:

1) Make informed decisions about effective behavioral health interventions for children and families
2) Identify the fundamentals of how to assess and treat behavioral health problems in children and adolescents
3) Effectively treat the most commonly occurring behavioral health needs of children and families

This certificate program would offer students 15 CEU's and include the three (3) current graduate courses (detailed in the next section) in addition to at least one more course offering.

Kerns et al 2016 found that students who took any of the three courses, students rated themselves highest in treatment specific strategies and showed statistically significant improvement in general clinical self-efficacy (average = 5.14, SD = 0.71) on a scale of 1 to 7 (being the highest). These specific strategies were tailored for each course, reflecting the core skills required to provide direct service in that particular R/EBP.

A course series available to interdisciplinary graduate students at the University of Washington on the following topics:

Table 8: University of Washington Graduate Level Course Series

Quarter	Course	EBP/s of Focus
Fall	Effective Parenting Interventions (Parent-mediated interventions)	Helping the Non-Compliant Child
Winter	Clinical and Systems Interventions for Complex and Extreme Disorders	Trauma-Focused CBT
Spring	Behavior modification, behavioral therapy, and cognitive therapy skills	Components of Dialectical Behavior Therapy, Multisystemic Therapy, and Motivational Interviewing

CBT TREATMENT

This course provides students with an in-depth introduction to evidence-based, cognitive behavioral therapies (CBT) for children and adolescents with anxiety-related disorders, emphasizing treating child traumatic stress. Specific components of treatments commons across

most CBTs are highlighted, and training in Trauma-Focused Cognitive Behavioral Therapy's (TF-CBT) *TF0CBT Web*, an online training program. Students learn the fundamentals of how to assess and treat anxiety and trauma in children, as well as adaptations to match client presentation, ethnicity, culture, socioeconomic status, and treatment setting. Students gain knowledge through readings, a web-based training program, role-play, and are encouraged to practice skills outside of class in a variety of settings.

COMPLEX DISORDERS

This course provides students with an in-depth review of a range of EBPs appropriate for most extreme or complex cases in with youth and adolescent aged clients. These cases have behavioral and psychiatric disorders involved in multiple services systems, including mental health, juvenile justice, chemical dependency, school systems and special education, and child welfare/protective services. The course focuses on the clients, their families, and care providers, emphasizing a practical approach to acquiring necessary skills, attitudes, and knowledge to effectively work with this population. Students gain a practical understanding of the common elements as well as experimental learning of the following EBPs: Multisystemic Therapy, Family Integrated Transitions, Dialectical Behavior Therapy, and Relapse Preventions. Motivational Interviewing is included in the training as an enhancement to the EBPs.

PARENTING

This course is designed to provide students with a solid foundation for the practice of a specific evidence-based parent training approach. In addition to developing a sound foundation in a particular evidence-based parenting approach, *Helping the Noncompliant Child* (HNC; McMahon & Forehand, 2005), this course specifically addresses: 1) cultural considerations in working with families and implementing parenting interventions and 2) systems issues related to how evidence based parenting approaches are implemented in different settings (e.g., mental health, child welfare). Building upon the principles of evidence-based treatment approaches, this course will include the following components: Didactics (readings, lecture and in-class discussion), skills demonstration and practice (modeling, role-playing, and out-of-class rehearsal), and assessment (skills check-out, presentations, and written assignments). By the end of the quarter it is our goal that students have a general understanding of the benefits of evidence-based approaches, competency demonstrating the components of HNC, and a basic understanding of how to deliver HNC to families.

Table 9: Graduate Students Self-Reported General Self-Efficacy Therapeutic Practice Focus in R/EBP Course since September 2008

Variables by Course	Pre		Post		*t*	df	p
	M	SD	M	SD			
General Self-Efficacy							
Parenting (n=137)	3.11	1.13	5.42	0.64	-28.30	136	<0.01
CBT treatment (n=81)	3.15	0.96	5.35	0.67	-22.99	80	<0.01
Complex Disorder (n=48)	2.43	0.97	4.98	0.68	-17.04	47	<0.01

Table 9 shows the results of student's reported self-efficacy prior to the course and directly after, using a scale that ranged from 1-7 (7 = highest rating). This study found that students made statistically significant gains in self-reported knowledge and confidence in all three EBP training areas. Students were specifically asked "Do you currently feel adequately trained to conduct [parenting interventions, interventions for anxious youth and youth with PTSD, or youth/family interventions for adolescents with multiple systems involvement]?"

EVIDENCE-BASED PRACTICE LECTURE SERIES

LECTURE SERIES ATTENDANCE AND IMPACT

Figure 4: Total amount of 2016-17 Lecture Series Registrants by Reported Department Affiliation

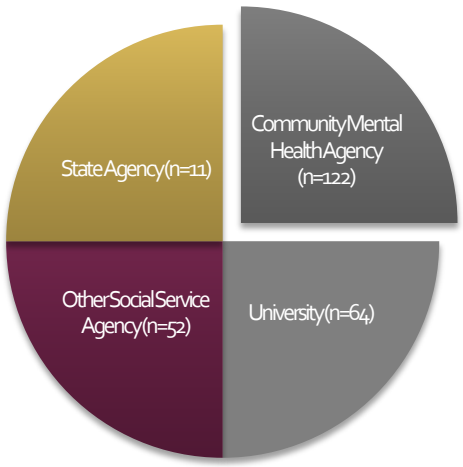

Table 10: Reported Impact of 2016/17 Lectures*

Impact	N*	Rating
Did the lecture met expectation?	99	6.01
Would the lecture be useful in daily work?	99	5.97

Ratings range from 1 to 8 (highest rating)

**Represents those who chose to complete the post lecture survey. Does not reflect total participants.*

The FY17 workforce lecture series featured six (6) lectures: one (1) was in-person in the community, one (1) pre-recorded webinar, and four (4) live-webinars (see table 11).

This year's lectures were the first to be predominately web-based. Employing a departmental subscription of a web-based video conference system, Zoom, EBPI was able to track and survey participants of webinars. A total of **296 people** registered for our lectures (248 attended), n=47 did not nominate a department affiliation upon registration (see Figure 4). Our survey average response rate was 54% (n=99), with an average of 37 participants per lecture, and with an overall 145% increase in participants in fiscal year 17 compared to fiscal year 2016 (see Table 10).

The lecture series are consistently well reviewed: 69% of surveyed lecture participants rated that they were very or highly satisfied with this year's content (scale 1-8, highly satisfied being a score of 6 or higher) with regards to expectation of the lecture being met and usefulness in daily work life (see table 10).

Table 11: EBP Workforce Lecture Series for 2016-17

Lecture Date (Format)	Lecture Title and Presenter(s)	Total Number of Attendees
October 6th, 2016 (Live Webinar)	"Organizational Perspectives on Implementing and Sustaining EBPS in Community Mental Health" with Dr. Georganna Sedlar and Community Mental Health Agency Panel	41
November 4th, 2016 (In-person in King County)	"Promoting First Relationships" with Drs. Susan Spieker and Monica Oxford	24
January 12th, 2017 (Pre-Record Webinar)	"Disruptive Mood Dysregulation Disorder: Fix, Future, or Fad?" with Terry Lee, MD	42
March 9th, 2017 (Live Webinar)	"Evidence based practices in diagnosis and intervention in Autism Spectrum Disorder" with Dr. Raphael Bernier and Rachel Earl, Ed.S.	93

April 13th, 2017 (Live Webinar)	"Implementing Evidence-Based Practices for Children with Autism in Public Schools" with Dr. Jill Locke	22
May 11th, 2017 (Live Webinar)	"Children's Mental Health Legislation" with Dr. Eric Trupin	26

EVIDENCE-BASED PRACTICE INTER-UNIVERSITY INITIATIVE

The Workforce Taskforce in EBPs transitioned from an interdisciplinary team of faculty within the University of Washington to the EBP Inter-University Initiative with expanded membership from private and public universities throughout WA State (Table 12). This expansion occurred as a result of a survey conducted in 2016 by EBPI sought to identify the extent to which schools were teaching EBPs at the graduate and undergraduate level in programs which typically graduate students into the social service and community mental health fields. Participants of the survey were then invited to join the taskforce with a primary objective to think about ways to integrate EBPs within their curriculums. The taskforce met throughout the year to discuss strategies for integrating evidence-based practice in graduate training curricula as well as strategies for encouraging the use of EBPS in the community workforce. Below is a list of participating education entities:

Table 12: University R/EBP Curriculum Participants

University Name	Number of Participants	Associates, Undergraduate, and/or Graduate Programs offered
Lake Washington Technical College	1	Associates and Undergraduate
Central Washington University	1	Undergraduate and Graduate
Pacific Lutheran University	1	Undergraduate and Graduate
City University	1	Undergraduate and Graduate
Heritage University	1	Undergraduate
Gonzaga University	1	Undergraduate and Graduate
Eastern Washington University	2	Undergraduate and Graduate
Washington State University	5	Undergraduate and Graduate
Antioch University	1	Undergraduate and Graduate

STATE NEEDS ASSESSMENT AND PLANNING FOR FY17/18

EBPI conducted its annual needs assessment earlier than usual this year in order to allow more time to plan around conflicting trainings and priorities for BHOs and agencies. In the past, EBPI and the WSU Behavioral Health Workforce Collaborative have engaged in separate annual needs assessments for their menu of trainings to outpatient mental health providers and WISe providers. In an effort to collaborate on these surveys and reduce the time burden on clinicians, the two organizations collaborated to include questions for those providing WISe services in addition to general public mental health training and support needs.

Similar to previous years, an online survey was developed and the link distributed to each BHO to disseminate among their provider network. They were asked to complete the survey within a two week time frame. Results of the needs assessment are listed below.

General demographic information was gathered from each participant, and further broken up to differentiate between general outpatient providers (Table 13) and WISe team members (Table 14). A total of 169 surveys were completed, with participation from all ten Behavioral Health Organizations (BHO). Participants had a range of job titles, with agency administrators (n=45) and direct service providers (n=44) accounting for most of the responses. The King region had the highest number of participants (n=44), which aligns with the large number of provider sites that fall within their county. Pierce/Optum had the lowest response rate (n=3) from their provider sites, which could be the result of a recent staff change in care coordinator roles.

Table 13: BHO participation

BHO	Count
Great Rivers	20
Greater Columbia	13
King	44
North Central	12
North Sound	13
Pierce/Optum	3
Salish	13
Spokane	20
SW RSA	8
Thurston/Mason	6
Missing	17
Grand Total	**169**

Table 14: Survey Participant Identification

Job Title	Count
Supervisor	11
Youth/family support	6
Non therapy support staff	11
Agency Administrator	45
BHO Administrator	5
Direct Service Provider	40
WISe Care Coordinator	15
WISe Therapist	18
Missing	18
Grand Total	**169**

Youth/family support - peer support and parent partners

Non therapy support staff - care coordinators, facilitators, program managers

Respondents were provided with a list of the current training and technical assistance offerings that EBPI has developed. They were then asked to rank these trainings in order of interest, from

most interesting to least interesting. Results indicated that the majority of the BHOs were interested in the training "Engaging Families in Children's Mental Health Treatment" (5/10), followed by "Implementing EBPs with Families Facing Adversity" (4/10), and then with EBPI's newest training for families with adolescents experiencing disruptive behaviors (STAY) at 3rd with 3/10 ranking it as their top preference. The EBP Reporting Guides will be offered to each region regardless of their interest as a technical assistance tool for using the guides when reporting EBP SERI codes. In addition to this live training, a brief animated video was developed by EBPI to walk providers through the EBP Reporting Guides step by step.

Table 15: Means of EBPI Technical Assistance Ranked by BHO

BHO	N	Engaging Families	Implementing EBPs with Crises	STAY	EBP Reporting Guides Pilot Sites	Write-in #1	Write-in #2
Great Rivers	20	2.07	2.14	2.21	4.14	4.43	6.00
Greater Columbia	13	2.75	1.50	2.25	3.50	5.00	6.00
King	44	2.06	2.65	2.16	3.58	4.74	5.81
North Central	12	2.13	3.00	1.38	3.50	5.00	6.00
North Sound	13	2.38	2.13	2.13	4.00	4.63	5.75
Pierce/Optum	3	4.00	1.50	2.50	4.00	3.00	6.00
Salish	13	2.56	1.89	1.89	3.89	4.78	6.00
Spokane	20	1.83	2.75	2.08	3.67	4.67	6.00
SW RSA	8	1.33	2.67	2.00	4.00	5.00	6.00
Thurston/Mason	6	1.20	2.20	2.60	4.00	5.00	6.00
TOTAL*	152						

**N total does not reflect the 17 surveys which were missing a BHO designation and as a result not included in the totals above.*

Table 16: A List of Write-in Options by BHO

BHO	Listed Write-in Options
Great Rivers	ARC
Greater Columbia	N/A
King	Free or affordable Triple P, IY, PCIT, DBT, Early Onset Psychosis, CANS Care Plans, CANS training, Cultural Competency, Support clients around getting access to timely WRAP support, CLIP application, Safety and crisis planning, How Therapist can work effectively with WISe, Motivational Interviewing Care with those with multiple traumas, Working with the Latino Community, Advanced Crisis Planning, General Advanced Training, PSTD for Children, Family Support and Outreach, TF-CBT, Suicide Interventions, Coping Strategies, Training on watch recovery looks like, Team Development, Advanced Facilitation Skills, LGBTQ affirming Training, and Bi-cultural training
North Central	EBPs or RBPs in Play Therapies and/or Creative Arts/Experiential Therapies
North Sound	CBT+, DBT
Pierce/Optum	N/A
Salish	EMDR, DBT, Triple P, PCIT, Motivational Interviewing, CBT, CBT+
Spokane	Trust Based Relational Therapy
SW RSA	CBT+ through Harborview
Thurston/Mason	Working with Harborview/EBPI to make CBT- Family, looking at core elements rather than strict fidelity. Transition Phase (of wrap around/WISe) training on equipping families with access to supports that help sustain gains made.
BHO	N/A

Respondents who identified themselves as working within a WISe team were asked about topic areas they were interested in for advanced trainings and coaching calls. Answers were write-in only and our research team coded each response into the sections listed in Table 17.

Advanced training in functional skills (n=14) was reported as a need among the majority of respondents. This included safety and crisis planning, trauma, family support strategies, and how to manage disruptive behaviors. Following in a close second was skills related to care coordination (n=12), such as how to strategically use the CANS, how to develop sound care plans, and best practice around care coordination. Specific programs or practice of interest reported by

respondents (n=10) were Motivational Interviewing, Cognitive Behavioral Therapy, Trauma-focused CBT, and Dialectical Behavior Therapy.

Results were similarly distributed among content areas of interest for coaching calls, with a majority citing functional skills (n=10) at the top. Some examples of these were diagnosis and assessment, setting goals, and crisis planning. Care coordination was listed as second (n=8), and included write in responses such as effective communication among team members and system partners. Responses that discussed the need for assistance with engagement was of moderate concern (n=6), followed by special populations (n=2) like working with kids who have autism, and specific program or practice (n=1) coming in last.

Table 17: WISe Intensive Services Capacity

	Currently unavailable	Available, but have yet to occur	Available with some occurrence	Available with frequent occurrence	R/EBP is being used for this
Educating the youth's family about the mental health challenges the youth is experiencing, and how to effectively support the youth	3	1	8	10	5 ARC, Circle of Security, med mgmt
In-home functional behavioral assessment	7	2	3	10	3 CANS
Behavior mgmt., including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family	7	1	5	8	3 DBT, Non-violent crisis intervention
Improve self-care by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others					CBT and MI
Improve self mgmt of symptoms including self-administration of medications	4	2	10	5	2 CBT, MI, telemedicine
Improve social functioning by addressing social skills deficits and anger mgmt.	2	2	6	10	6 ARC, CBT
Reduce negative effects of past trauma, using R/EBPs	2	3	6	7	6

					TFCBT, ARC, DBT, CBT
Reduce negative impact of mental health disorders using R/EBP	2	5	5	5	7 ARC, DBT, CBT, TFCBT
Support the development and maintenance of social support networks and the use of community resources	3	2	7	10	1
Support employment objectives by identifying and addressing behaviors that interfere w/seeking and maintaining a job	5	2	10	4	1 Psychotherapy, CBT
Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community	3	2	4	12	2 CBT, DBT, IEPS
Support independent living objectives by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently	4	2	7	8	1

Washington State's Wraparound with Intensive Services (WISe) has a manual created to ensure the program's competence and consistency throughout the state. The WISe manual (https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20Manual%20v%201.7-FINAL.pdf) lists a number of services which are part of the intensive services menu that teams are expected to provide families within the WISe program. Each service was listed in the survey and participants were asked to what level of capacity (none to frequent) they are currently able to deliver each service, and, if applicable, are they using an R/EBP to do so.

A majority of the responses indicated that they were able to provide these services with at least some frequency of occurrence, with 8/12 categories frequently occurring. R/EBPs that were reported for use within these services included CBT, DBT, and MI. There were several programs reported that do not technically qualify as an R/EBP in WA State such as Circle of Security, ARC, and non-violent crisis intervention.

Services reported as unavailable at this time had lower responses, but still ranged from 2-7 participants. This could be the result of some BHOs who are in the early stages of WISe implementation and as a result have yet to either start or establish protocols for providing this service.

WORK CITED

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