Evidence Based Practice Institute

FY 2019 Annual Report

Engrossed Substitute House Bill 1109; Section 215(52); Chapter 415; Laws of 2019

December 1, 2019

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Acknowledgements

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Table of Contents

Executive summary

The Washington State Health Care Authority (HCA) submitted this report to the Legislature as required by Engrossed Substitute House Bill 1109 (2019):

> *$446,000 of the general fund—state appropriation for fiscal 15 year 2020, $446,000 of the general fund—state appropriation for fiscal year 2021, and $178,000 of the general fund—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 authority to develop a plan to seek private, federal, or other grant funding in order to reduce the need for state general funds. The authority 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 1 of each year of the biennium.*

This report from the Washington State Health Care Authority (HCA) and University of Washington School of Medicine's Evidence Based Practice Institute (EBPI) will ensure the Legislature has the information requested regarding the efforts and impacts of EBPI and the efforts to obtain funding other than state general funds. In addition to the efforts to obtain grant funding, the report describes efforts by EBPI in four major areas of emphasis:

- Training and technical assistance to mental health providers on the use of evidence-based practices.
- Research into the use of evidence-based practices in Washington.
- Policies to improve use of evidence-based practices.
- Ongoing development of a university workforce initiative to support training on the use of evidence-based practices by mental health clinicians in training.

Additional funding

2019 ESHB 1109 Sec 215 (52) directs HCA's Division of Behavioral Health and Recovery (DBHR) to fund the EBPI and requires HCA and EBPI to develop a plan to seek additional funds to support EBPI's scope of work. In 2019, EBPI will seek funds from the following sources to evaluate and expand programs, as follows:

1) William T. Grant Foundation – Use of research evidence

$850,000 Walker (PI)

The project would track the use of research among decision makers in public systems using bibliometric analysis and assess the value of Rapid Evidence Reviews to increase the use of research in decision making.

2) University of Washington Department of Psychiatry and Behavioral Sciences – Systems approach to opioid crisis

$50,000 Walker (PI)

The project would develop a systems-level assessment tool for multiple sector approaches for tackling opioid prevention, use and abuse.

3) STAY (Slow down/Take Interest/Assess your role/Yield to another perspective) training

EBPI piloted a fee-based training for STAY on June 20, 2019 in Seattle. The training was open to anyone interested in attending, and specifically marketed to:

- The Association of Mental Health Counselors;
- The National Association of Social Workers;
- The Health Care Authority;
- Educational institutions;
- Washington Council for Behavioral Health;
- Managed care organizations (MCOs); and
- Behavioral health organizations (BHOs) throughout the state.

A total of 34 people registered for the event, and 20 participants attended the live training. Participants were charged $150, netting a gain of $3,000.

Community workforce

EBPI provides a community workforce portfolio, including research, policy, and direct training and technical assistance to community children's mental health providers and agencies. EBPI works closely with HCA via regional BHOs and MCOs 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 areas of focus in State Fiscal Year (SFY) 2019:

- **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 regional directors and providers. In FY19, EBPI trained more than 340 community mental health providers, through its STAY, WISe Autism training, and WISe Cultural Humility training programs.

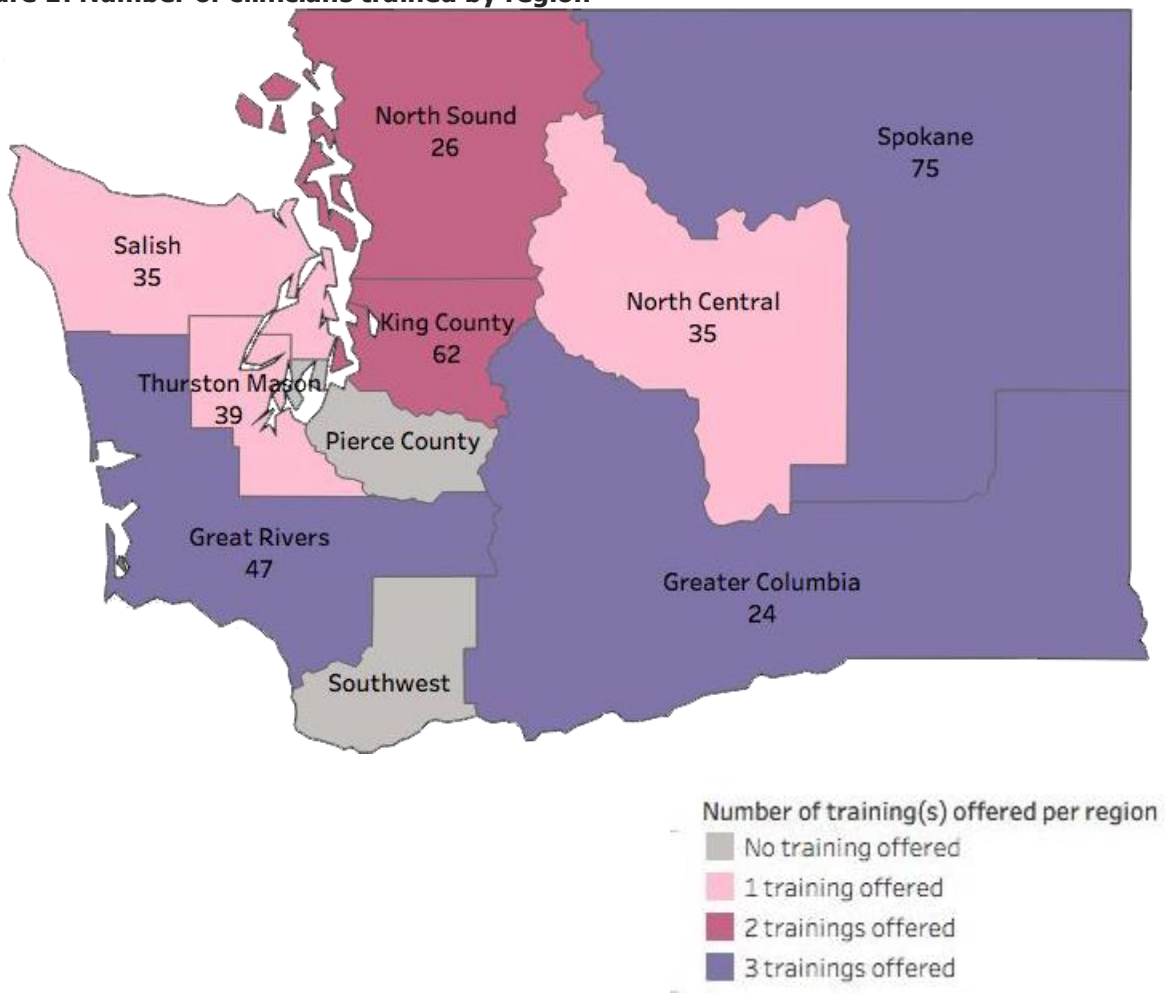
- **Policy:** EBPI partners with HCA to develop policy solutions to research translational challenges. Over the past four years, EBPI has focused on developing a Reporting Guide to assist providers in accurately reporting and documenting the use of evidence-based practices. In addition to identifying the formulas for monitoring research and evidence-based practices (R/EBPs) through billing codes, EBPI has developed a regional evidence-based practice (EBP) performance report to track state, BHO and individual provider-level EBP rates. Parallel to this effort, EBPI is also actively seeking feedback on data accuracy and identifying challenges of EBP reporting.

- **Research:** With support from Amerigroup and HCA, EBPI is launching a pilot study to assess the feasibility of performing organizational EBP reporting capacity assessments, validate EBP reporting fidelity through billing codes, and measure the impact of an enhanced payment model on therapist behaviors. During the last fiscal year, EBPI continued to collaborate with HCA and other partners to conduct research on topics that will forward the use of EBP in public mental health settings. Partnerships include ongoing collaboration with Washington State University on a client report study focused on EBP satisfaction and mental health outcomes. EBPI also conducted a number of literature reviews and qualitative coding projects on the topics of consultation requirements of EBP training, evidence of peer support, and the influence of cultural differences when using various EBP techniques.

Training and technical assistance

In FY19, EBPI offered three direct training opportunities (STAY, WISe Autism, and WISe Cultural Humility) and a two-part webinar training (Brief Youth Suicide Assessment and Intervention Strategies). In total, 343 providers across eight regions received in-person training. The online webinar garnered 233 participants.

Figure 1: Number of clinicians trained by region



WISe Autism training: Understanding Autism Spectrum Disorder and Strategies to Support Positive Behavior

In collaboration with the UW Autism Center, EBPI offered Understanding Autism Spectrum Disorder and Strategies to Support Positive Behavior training to 180 providers in the Greater Columbia, Thurston Mason, Great Rivers, Spokane, Salish (BHO), and North Central (MCO) regions. The training provides psychoeducation about Autism Spectrum Disorder (ASD) along with evidence-based strategies from the principles of Applied Behavior Analysis that includes tips for coaching family members to implement simple and practical strategies.

Feedback from providers

During the previous fiscal year, 180 community mental health providers across 32 agencies participated in the WISe Autism training. On a scale of 1 to 5, the overall quality of the training was rated 4.8 (n=131), the presentation of topics was rated 4.8 (n=130), quality of handouts was rated 4.6 (n=131), and the activities and discussions were rated 4.7 (n=131). On a scale of 0 to 4, the overall helpfulness was rated 3.8 (n=130).

Table 1: Provider feedback scores

	Quality (1-5)	Topics (1-5)	Handouts (1-5)	Activities (1-5)	Helpfulness (0-4)
RESPONSES (N)	131	130	131	131	130
AVERAGE	4.76	4.78	4.55	4.65	3.77

WISe Cultural Humility workshop

Cultural Humility training encourages participants to explore how culture impacts client participation as well as how the perception of treatment effectiveness can improve client participation and motivation. This workshop focused on increasing awareness of cultural barriers and opportunities to improve cultural sensitivity and humility. This training was offered to 112 providers across King County, Spokane, Greater Columbia, Great Rivers, and North Sound BHO.

Feedback from providers

Providers from 26 agencies have rated this training. On a scale of 1 to 5, the overall quality of the training was rated 4.8 (n=76), the presentation of topics was rated 4.8 (n=75), quality of handouts was rated 4.7 (n=75), and the activities and discussions were rated 4.8 (n=74). On a scale of 0 to 4, the overall helpfulness was rated 3.8 (n=75).

Table 2: Provider feedback scores

	Quality (1-5)	Topics (1-5)	Handouts (1-5)	Activities (1-5)	Helpfulness (0-4)
RESPONSES (N)	76	75	75	74	75
AVERAGE	4.83	4.73	4.69	4.81	3.73

STAY (Slow down/Take interest/Assess your role/Yield to another perspective)

In this fiscal year, EBPI continued to expand coverage of STAY, a brief family-based treatment for adolescents with behavior problems. STAY works best as a frontline strategy to involve family members in their adolescent's treatment and provide them with basic skills to improve communication and reduce conflict. STAY also works well for families that require more intensive intervention where family conflict and behavioral issues are of primary concern.

The model uses a hybrid of evidence-based strategies and techniques that include parent management training and components of cognitive behavioral therapy, which are delivered through a multi-step approach over the course of four stages (length of treatment depends on the needs of the family). STAY consists of four basic principles and a problem-solving framework, which encourage the family/client to:

1. Slow down
2. Take interest
3. Assess your role
4. Yield to another perspective

These are accomplished by 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 structured approach for therapists while remaining flexible to meet the needs of diverse families and youth.

The training covers 13 sessions using the following format:

1. **Live training:** Full-day, in-person training (7 hours).
2. **Consultation:** Participants are required to participate in 9 to 12 follow-up consultation calls with trainers.

Feedback from providers

In total, 63 participants from 17 agencies rated this training. On a scale of 1 to 5, the overall quality of the training rated 4.7 (n=51), the presentation of topics rated 4.8 (n=51), quality of handouts rated 4.7 (n=51), and the activities and discussions rated 4.6 (n=51). On a scale of 0 to 4, the overall helpfulness rated 3.8 (n=50).

Table 3: Provider Feedback Scores

	Quality (1-5)	Topics (1-5)	Handouts (1-5)	Activities (1-5)	Helpfulness (0-4)
RESPONSES (N)	51	51	51	51	50
AVERAGE	4.69	4.78	4.71	4.59	3.84

Youth Suicide Assessment and Prevention Strategies two-part webinar

EBPI invited two expert clinical psychologists from Seattle Children's Hospital to present the Youth Suicide Assessment and Prevention Strategies webinar series, designed to meet the needs of the provider community. The webinar contained two parts:

- Part I: Orientation to the issue and screening approaches, and Part II: Management and treatment strategies.
    - Part I presented a framework for assessment with a focus on identifying risk and changes that may exacerbate risk.
- Part II offered insights into safety and intervention strategies to augment the therapeutic value of these crisis prevention interventions.

Feedback from providers

This webinar series was met with positive feedback. In total, 170 mental health practitioners across the state attended Part I, and 140 attended Part II.

Table 4: Part I feedback scores

	Helpfulness	Topic	Example	Quality	Presentation	Presenters
RESPONSES (N)	57	56	56	57	56	57
AVERAGE (1-5)	4.49	4.66	4.32	4.54	4.46	4.58

Table 5: Part II feedback scores

	Helpfulness	Topic	Example	Quality	Presentation	Presenters
RESPONSES (N)	53	53	53	53	53	53
AVERAGE (1-5)	4.72	4.77	4.72	4.72	4.64	4.83

Supervision consultation project

Supervisors play an integral role in the implementation and sustainment of effective behavioral health practice. EBPI is leading a pilot project involving consultation and support to behavioral health supervisors in their supervision of direct providers. Consultation will be case-based, meaning that they will focus on actual cases being supervised. These types of calls have shown to be helpful for clinicians in implementing interventions, and EBPI would like to examine the feasibility of applying this model to supervisors.

Consultation calls will last one hour and occur twice a month for six months, for a total of 12 consultations. A remote web platform will engage supervisors from various geographical areas in Washington State. We anticipate having between 8 and 10 supervisors at each consultation. The calls will consist of a brief didactic (15 minutes) with the remaining time spent on discussion of cases that are being supervised.

Research

Behavioral incentives for increasing quality care in children's mental health: Washington study

EBPI is launching a pilot study on streamlining, monitoring, and support options for improving client outcomes in children's mental health and behavioral health systems. The study includes three areas of focus:

1. Assessing the feasibility of an organizational capacity assessment that aids decision-making for supporting high-quality children's mental health care..
2. Examining the acceptability and value of incentives applied towards agency performance benchmarks.
3. Validating the administrative reporting of evidence-based practices through billing codes.

Study recruitment will start with four community mental health agencies located in Yakima, Tri-cities, and Wenatchee.

Advancing the state-level tracking of evidence-based practices: a case study

With key HCA staff, EBPI published a paper in the International Journal of Mental Health Systems titled "Advancing the state-level tracking of evidence-based practices: a case study." The article describes the approach to measuring the quality of psychosocial interventions through therapist-reported practices. It concludes that the strategy developed in Washington State is a feasible

method of collecting session-level information about the use of effective mental health practices. The paper was presented at the National Institute of Mental Health's 2018 Mental Health Services Research Conference.

Research on integrating evidence-based practice reporting to guide health policy

EBPI's abstract was selected for presentation as part of a symposium at the 2019 Society for Implementation Research Collaboration (SIRC). EBPI presented research on integrating evidence-based practice reporting and client surveys to guide decision-making in a learning health care system. As a proof of concept, we demonstrate that billing data provides a cost-effective tool to monitor the receipt of EBP mental health sessions and can be tied to other data sources to examine outcomes across a health network.

Cultural responsiveness paper

EBPI developed a survey in 2013 as part of a deliverable within the state-funded contract to assess the cultural responsiveness of evidence-based practices across the three child-serving systems at the time (Mental Health, Juvenile Rehabilitation, and Children's Administration). The survey was distributed to providers via an online link and received 71 responses. The results of the survey were developed into a report and submitted to the State at the end of the state fiscal year 2014.

EBPI staff and faculty are analyzing both the quantitative and qualitative data to develop a manuscript for publication. The survey explores participants' perspectives about specific EBPs and their cultural responsivity, as well as specific elements and strategies within those EBPs. Additionally, participants were asked to note specific cultural characteristics of the clients in which they reported differences or no differences between group responsiveness to specific EBPs and EBP elements. A paper will be submitted for publication by the end of 2019.

STAY evaluation

EBPI has trained 146 master's-level mental health clinicians in the STAY model since its inception in 2017. Throughout the training process, EBPI collected data using evaluations, a client questionnaire, and in-depth qualitative interviews.

Table 6: Demographic data – client questionnaire

Category	
Age (range)	7-17
Ethnicity	
Caucasian	17
Hispanic	12
African American	2
Native American	2
Unspecified	1
Gender	

Male	17
Female	16
Transgender	1
Diagnosis (multiple)	
Disruptive Behaviors/ADHD	7
Mood/Depression	13
Anxiety/PTSD	14
PDD/Autism	2

In addition to a brief questionnaire distributed monthly to clinicians who participated in STAY trainings, EBPI conducted an in-depth qualitative survey with a selection of therapists trained in the model. All therapists who participated in a training in the past six months were invited participate. Six individuals were interviewed.

Table 7. Qualitative survey interview responses

Survey Question	Response
Average number of clients	4.3
Average number of sessions completed	4
Common family goals	More effective communication, increase desirable behaviors
Common outcomes	Increase in positive communication, parental listening skills, getting families on the same page
Strengths of the model	Family participation and involvement, brief duration, consultation calls
Challenges of the model	Sometimes can be a challenge with clients showing up and those who are high intensity

A majority of respondents in both surveys reported that their clients had previously been in individual counseling and found STAY to be a helpful addition to the therapeutic process. Many reported the STAY model was very effective at improving family communication and increasing parents' listening skills. The key elements of slowing down and helping the family to manage emotions and explore their interaction cycles appeared to be the most helpful strategies, while many reported that parenting skills were not always needed with a number of their clients.

WISe clinician training needs assessment

In collaboration with the WISe Workforce Collaborative, EBPI assessed the training needs of clinicians serving WISe teams. Clinicians were asked to complete a survey at one of two WISe trainings in March and June. Results are displayed in three tables, addressing 1) Major areas of training need; 2) Specific training programs preferred; 3) Preference for modality of training and support.

Table 8: Diagnoses training needs (N=122)

Major Categories	N (%)
Depression	16 (13.1)
Anxiety	11 (9.0)
Disruptive (any mention of violence, aggression, attention problems)	35 (28.7)
Developmental (autism, fetal alcohol spectrum disorders, or the like)	28 (23.0)
Trauma (post-traumatic stress disorder, trauma, abuse)	17 (13.9)
Family needs (parent treatment or economic needs)	1 (0.8)
Support working with parents/families in their child's treatment	2 (1.6)
Personality disorders	4 (3.3)
Psychotic disorders	5 (4.1)
Addiction (substances and technology)	3 (2.5)

Table 9: Name brand training needs (N=91)

Brand Name	N (%)
Mindfulness and DBT	19 (20.9)
CBT (CBT-TP, TF-CBT, ARC, Self-regulation)	21 (23.0)
Trauma Informed Care	3 (3.3)
ABA	3 (3.3)
EMDR	14 (15.4)
Play therapy/Sandtray	5 (5.5)
Motivational Interviewing	5 (5.5)
Family systems therapy (STAY, PPP, Family Therapy)	5 (5.5)
Solution focused (Collaborative Problem Solving/Collaboration proactive solution)	3 (3.3)
Somatic (Somatic Experiencing)	2 (2.2)
Other (EFT, TBRI, EMOR, Dream Analysis, Self-Care, Lifespan Integration, Harm reduction, Hypnotherapy, Attachment Therapy, CANS)	11 (12.2)

Table 10: Preferred method of training needs (N=71)

Brand Name	N (%)
In-person	39 (54.9)
Remote	11 (15.5)
Case consultation	13 (18.3)
Written materials	8 (11.3)

Policy

2019 Reporting Guide for research and evidence-based practice in children's mental health

Utilizing a research-grounded and innovative approach to monitor evidence-based practices at the state-level, the EBP Reporting Guide provides step-by-step instructions for clinicians to report research and evidence-based practice (R/EBP) for children's public mental health care (under 18 years of age). Following the common element framework, EBPI continued to improve the Reporting Guide by including a broader range of training entities and programs as suggested by the most recent clinical guideline papers and frontline providers. The current version also includes expanded treatment plan documentation examples and core element listing.

In previous years, these evidence-based practices were only reported by behavioral health agencies in a BHO region. As the state expanded the number of regions that are fully integrated into managed care, the Service Encounter Reporting Instructions (SERI) were updated for all providers in the state that bill Medicaid. This results in capturing all children's mental health encounters in every region of the state, including the low- to moderate-intensity cases that were not part of BHO contracted work.

EBPI also helped draft HCA's January 1, 2020, contract for Integrated Managed Care (IMC), Section 7.9 Mental Health Evidence-Based Practices (EBPs). EBPI suggested that contractors require the reporting of R/EBPs by qualified mental health providers to clients under the age of 21. Reporting must use SERI and the EBP Reporting Guide.

Regional EBP performance report

In support of HCA and the Washington State Department of Social and Health Services Research and Data Analysis (DSHS/RDA), EBPI is now receiving routine state, BHO/MCO, and agency-level EBP data.

To assess data accuracy, EBPI conducted a survey to verify how well the quarter 2 data (April to June 2018) matched with agencies' reported and actual used rate of EBPs. Among the 32 clinical directors who responded to the survey, 41.9 percent indicated this data matched "very well" with their reported use of EBPs; 22.6 percent indicated the data matched "a little;" and 35.5 percent responded "not well." Additionally, 18.8 percent of clinical supervisors/directors indicated that the state data represented their actual use of EBPs "very well;" 12.5 percent rated "a little;" 59 percent rated "not well;" 9.4 percent of agencies did not respond to this question. Most agencies estimated their actual use of EBPs to be in the range of 31 percent to 50 percent, followed by 51 percent to 70 percent.

Qualitative results show that many agencies identified difficulties with using electronic health records, administrative burdens, heavy case load, and EBP training costs as primary barriers to accurate reporting.

Table 11. Results of EBP rate verification survey

BHO	Total responded	Total # of agencies	Response rate	Reported "very accurate"	Reported "a little accurate"	Reported "not accurate"
Greater Columbia	5	7	71%	40%	40%	20%
Great Rivers	7	9	78%	57%	14%	29%
King	7	13	54%	29%	14%	57%
North Sound	3	5	60%	33%	33%	33%
Salish	1	1	100%	0%	100%	0%
Spokane	4	13	31%	50%	0%	50%
Thurston Mason	4	5	80%	50%	25%	25%
TOTAL	31	53	58%	42%	23%	35%

Update of the WSIPP inventory

As of May 1, EBPI received four Promising Practice applications for inclusion in the 2019 Washington State Institute for Public Policy's (WSIPP) Inventory of Evidence-Based, Research-Based, and Promising Practices:

- **Youth Mental Health First Aid**: A program designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is in crisis or is experiencing mental health or addiction challenges.
- **King County Family Treatment Court (KCFTC)**: Serves parents who have lost custody of their children due to substance abuse issues. The program recognizes that most KCFTC participants will have a history of complex trauma which impacts not only their sobriety but their ability to parent effectively, maintain employment, secure housing, and access services.
- **Partners for Change Outcome Management System (PCOMS)**: Incorporates robust predictors of success into an outcome management system that partners with clients while honoring the daily pressures of frontline workers. PCOMS uses two, four-item scales to solicit service user feedback regarding factors proven to predict success, regardless of provider model, orientation, or presenting problem:
    - Client assessment of early progress (using the Outcome Rating Scale or ORS)
    - Quality of the alliance or match with the provider (using the Session Rating Scale or SRS)
- **Rites of Passage Wilderness Therapy**: The Rites of Passage Wilderness Therapy has a mission to promote unique experiences in the wilderness by establishing a community of individuals through a safe, structured curriculum and environmentally sound practices. Curriculum is designed to help students succeed by developing their ability to care for themselves, their environment, and their community.

EBPI and WSIPP will review program manuals, evaluation, treatment models, and relevant research to reach consensus on the designation. Joint decisions are announced in early September with inventory publication in December.

University workforce

EBPI developed a university-based workforce initiative in 2009 to address a gap between post-secondary training in providing EBPs and the low availability of children's mental health services in public service. 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 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 task force focused on disseminating evidence-based practices in multiple venues of mental health care advanced training.

Inspiring Innovations: 2019 Behavioral Health Workforce Summit

In order to enhance and expand a behavioral health workforce to meet the health needs of Washington residents, EBPI partnered with the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center and the Integrated Care Training Program (ICTP) to develop community-academic partnerships. Three webinar sessions were conducted to engage stakeholder groups and inform the 2019 summit planning process.

To ensure broad coverage across the state, the summit was hosted on April 3 in Spokane and again on April 5 in Seattle. More than 100 stakeholders working in education, workforce, and/or policy participated (37 in Spokane; 70 in Seattle). A summit summary and accompanying materials were sent to attendees as well as invitees who were unable to attend.

The summit included framing remarks, a keynote address, panel discussion, press conference-style sessions, and breakout sessions. Key themes of the summit included:

- The need to expand incumbent provider skills and rethink provider roles to deliver evidence-based practices (EBPs) within team-based, integrated behavioral and physical health care settings.
- Recognizing the increasing workforce shortage and the need to recruit and retain a behavioral health workforce.
- The need to address credentialing, licensing, and policy issues, as well as paperwork and documentation burdens.

Panels included representatives from government agencies, managed care organizations, behavioral health care clinics, and higher education. Panelists identified current local and regional

challenges, as well as those of rural and urban communities. Highlights included training in fundamental behavioral health skills, capitalizing on remote technologies, creating new workforce pathways (e.g., non-degreed, non-credentialed), utilizing peer- and community-based supports, aligning behavioral health education and workforce skills, and funding challenges to recruit, train, and retain a behavioral health workforce.

Press conference sessions provided opportunities to learn about current innovative practices for workforce development. These included educational programming to enhance skills of the behavioral health workforce, projects to implement short-term EBPs in primary care settings, and efforts to draw from existing resources and local expertise to enhance workforce skills in EBPs. Stakeholders who expressed interest in following up with innovators were connected after the summit.

Attendees self-selected to participate in policy, industry/workplace, or education breakout sessions. Group participants were charged with reflecting on summit discussion and developing a specific action plan to tackle a critical workforce need. These plans were shared with all summit participants.

Ideas and plans focused on:

- Creating a more diverse workforce that represents the diversity of communities
- Developing ways to retain the current workforce.
- Identifying and developing behavioral health pathways and core competencies to train the workforce to their scope of practice within an integrated care framework.
- The need for supervisory/leadership training.
- Ideas to leverage community resources to help "grow your own" workforce.
- The need for industry and education to work closer together to bridge the skills gap.

Evaluations from both Spokane and Seattle indicated a majority of respondents (89 percent to 96 percent) found the various conference activities relevant to their work/practice and were satisfied with the time spent in the various conference sessions.

A follow-up webinar was held June 20 for summit attendees and led by EBPI and AIMS faculty. This session focused on learning what impact the summit had on their workforce development efforts to-date and ways to support integration and collaboration among stakeholders.

Courses

Cognitive behavioral therapies treatment

In the spring, 19 students attended a cognitive behavioral therapies (CBT) trauma-focused class. The course provided students with an in-depth introduction to evidence-based CBT for children and adolescents with anxiety-related disorders, emphasizing treating child traumatic stress. Students learned 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. They also gained knowledge through readings, a web-based training program, and role-play, and were encouraged to practice skills outside of class in a variety of settings.

Table 12. Student evaluation scores

	Course as a whole	Course Content	Instructor Contribution	Instructor Effectiveness	Amount Learned
AVERAGE (1-5)	5.0	4.9	5.0	5.0	4.9

Table 13. Student qualitative responses

Survey Question	Response
Was this class intellectually stimulating? Did it stretch your thinking? Why or why not?	"Yes, it was. I learned a lot about anxiety disorders, CBT, and EBTs. I appreciated the lectures and class discussions. I especially appreciated Dr. Johnson's examples from her own clinical experience." "The practicality of this course was much appreciated! Being able to take the skills learned and immediately put them into practice is something that I wish we had more opportunities to access here in the university, especially since many of these courses tend to be closed to non-major students."
What aspects of this class contributed most to your learning?	"When the instructor modeled the skills checks. It was helpful to hear examples of language to use in a real life setting as opposed to just reading about it in a book." "Very well organized, practical experience, tons of real-world examples from the professor, weekly canvas discussions. All of it! One of (if not the) best class I took during my MSW."
What aspects of this class detracted from your learning?	"I had a hard time keeping up with the readings." "I think sometimes we had to rush through things due to time constraints, but that was okay."
What suggestions do you have for improving the class?	"I always love when the instructor brings in real life clinical experiences to use as examples, especially situations that were particularly difficult." "Continue to offer it!"