Integrated Youth Behavioral Health (IYBH) Program: Conceptual Framework and Culturally Competent, Evidence-Based Skills for MSW Students

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OVERVIEW: PRESENTATION
Learning Objectives

1) Develop and implement an integrated/interdisciplinary classroom/field curriculum for Master of Social Work (MSW) students to provide evidenced-based, culturally competent behavioral health care services to poverty-impacted youth.

2) Measure students’ learning using the Transcultural Self-Efficacy Tool (TSET) and the Evidence-Based Practice Attitude Scale (EBPAS).

3) Develop and utilize a video simulation demonstrating use of a suicide assessment tool to enhance classroom and field learning.
Integrated Behavioral Health Care for Youth/Families

- Coordinated, integrated, prevention-focused
- Interdisciplinary health professionals
- Physical, mental health, educational, family, psychosocial
- Education, prevention, and intervention services
Community Advisory Board

- Invited CEOs or designees to participate
- Interdisciplinary group (Social Work, Psychology, Psychiatry)
- Grant funding to engage through participation
  - in interprofessional education
  - in capacity building tools for agency use as well as MSW program use
  - in adjunct teaching
- Resulting in high engagement between the school and field sites
- Key decision-making and program planning throughout three-year program
Overview of Program Components
Silver School of Social Work
Focused Learning Opportunity (FLO)

- Classroom curriculum with specialized courses developed by faculty
- Specialized field learning sites and training
- Seminars
- Advisement
Classroom Curriculum

Required Courses
• Practice III: Social Work Practice with Youth and Families
• Trauma Elective: “Traumatized Children in Context” or “Core Concepts of Child and Adolescent Trauma”
• Policy II
• One Credit Intensive: Integrated Behavioral Health Concepts
• One Credit Intensive: Interprofessional Practice

Elective Courses
• Wide range of three and one credit courses
Integrated Behavioral Health Care For Youth/Families
Specialized Practice Strategies:
- Assessment/Screening Tools
- Prevention/Wellness Strategies
- Psychoeducation/Health Promotion

Evidence-based interventions:
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Mindfulness
- Trauma-Focused Approaches
- Family-Focused Interventions
Field Learning Curriculum

- Field instructors with expertise in evidence-based and interprofessional practice with youth and families

- Field placements in wide range of school, health, and community-based agency settings including:
  - Hospital Outpatient Health and Mental Health
  - Comprehensive Adolescent Health/Mental Health Centers [Hospital and Community Based Organizations (CBO)]
  - Hospital-based and School-based Health Centers
Field Learning Curriculum (cont’d)

- Community-based Health Settings
- Public Schools
- Agency/School Collaborative Day Treatment Settings
- Community-based Agency Settings: Day Treatment and Outpatient Mental/Behavioral Health
- Global Buenos Aires settings: Hospital; CBO’s, Group Homes; Youth Development
Practice III: Social Work Practice with Youth and Families

• Required second year Practice course, re-developed with Youth/Family focus

• Extend assessment and intervention skills with youth and families

• Overview of Practice Models with Youth and Families: Health/Mental Health; School-based; Prevention; Youth Development

• Assessment and Engagement with Youth and Families

• Evidence-based Intervention Models with Youth

• Engagement/Assessment with Parents and Family Therapy Models with Youth and Families

• Interprofessional Practice
Motivational Interviewing

- Ideal for adolescents: Supports client’s choice and Self-efficacy.
- Relies on strongly engaging the client to facilitate change for self.
- Language skills and reasoning capacity considered, children/adolescents.
- *Intrinsic motivation*, a necessary and sufficient factor in instigating change.

Goals of Motivational Interviewing:

- Support the enhancement of client's intrinsic motivation.
- Support the client’s self-efficacy.
- Assist the client to resolve ambivalence.
Cognitive Behavioral Therapy (CBT)

- Ideal modality for children/adolescents because of “here and now” approach.
- Helpful for children/adolescents to connect coping skills to concrete actions.
- Effective with anxiety, depression, cannabis/nicotine cessation, anger management.
Cognitive Behavioral Therapy (CBT) (cont’d)

- Uses modeling, coaching, and practicing new skills in between sessions.

- Age, cognitive development, language, perspective-taking ability, reasoning capacity, verbal regulation skills factors in determining appropriateness of CBT.

- Effective CBT interventions include journaling, homework, and completion of handouts.

- Three Areas of Skills: Cognitive Restructuring; Cognitive Coping; Problem Solving
Interpersonal Psychotherapy with Adolescents (IPT-A)

Brief, focused therapy, adapted to 12 sessions for depressed adolescents

Focus on how depression impacts adolescents’ interpersonal relationships:
- Family, friends, other interpersonal relationships

IPT-A focuses on therapeutic work in five areas:
- Grief; Interpersonal Disputes; Role Transitions; Interpersonal Deficits
  Single Parent Families
Family-focused Interventions

- Family context of utmost importance for children and adolescents.
- Poor families least likely to receive mental health care; lack service access.
- Parental attitudes re: services/providers, strong barrier to services.
- Use strategies to encourage parents to participate in services.
- Parents have own difficulties--creating challenges in parenting role.
- Integrated behavioral health addresses needs of all family members to gain better health.
Family-focused Interventions (cont’d)

- Key is: Non-blaming, supportive, collaborative relationship with parents.

- Recognize parenting struggles, empathize with adults in family.

- Compassion, empowerment, and cultural acknowledgement (not deficient-focused).

- Engaging families provides comprehensive understanding of family needs/concerns.

- Prevention re: teen pregnancy, diet, depression, anxiety, nutrition.
Family-focused Interventions (cont’d)

- Builds on parents’ strengths, and helps family members develop skills of resilience.

- Family resilience framework honors family kinship and cultural diversity.

- Resilience: beliefs; organization; flexibility; connection; communication; problem-solving.

- Evidence supported and other family therapy models enlist parental involvement.

- Examples: proactive sexual education re: sexual exploitation, pregnancy, STI’s, HIV.

- Important to build attachment between parent and child.

- Collaborative engagement, responsive to youth and parental perspectives/concerns, services to fit family needs, relevant, flexible, and strategies for obstacles follow-up.

- Response to needs of families led to models that include psychoeducation, multi-family groups, and parent empowerment.
Trauma Electives

Traumatized Children in Context

• Social work roles in prevention and intervention with traumatized youth
• Neurobiology of trauma and emotional regulation
• Resilience
• Self-care
• Assessment, prevention, treatment
• Family and School-based Trauma
• Collaborative practice with multiple systems
Trauma Electives (cont’d)

Core Concepts of Child and Adolescent Trauma

- Developed by Fordham University and Hunter College School of Social Work
- Core Concepts of trauma taught via Case Studies (18 months to 13 years)
- Problem-based and Group-focused Learning
One Credit Intensive:
Integrated Behavioral Health Concepts

• Integrated Behavioral Health for Youth—What is it? What is the social worker’s role?

• Diverse, evidence-supported frameworks for assessment, prevention, and intervention.

• Practical approaches to interdisciplinary collaboration and organizational culture.

• Culturally and linguistically competent practice for diversity regarding race, ethnicity, culture, gender expression, and sexual identity.

• Motivational Interviewing, CBT, Relaxation Training/Mindfulness, Psychoeducation, Case Management

• Understanding Psychotropic Medications and Collaboration with Psychiatry

• Alcohol and drug screening
One Credit Intensive: Interprofessional Practice

• Students learn how social workers, educators, and health care professionals collaborate to provide an integrated understanding of health, behavioral, and mental health perspectives.

• Examines challenges and opportunities for collaborative, interdisciplinary practice in behavioral health settings among these professionals.

• Health concerns conceptualized from broad perspective including, home, community environment, family, culture/language, socioeconomic status, mental health concerns, and behavioral patterns.

• Focus on interprofessional team-based care and increased understanding of interprofessional roles, relationship development, and conflict resolution across professions.

• Attention given to issues of hierarchy, power, professional culture and roles among diverse healthcare, education, and social work professionals.
Interprofessional Practice

- Core skill utilized by professionals across diverse settings.
- Collaboration/Consultation between allied health and behavioral health providers.
- Teams provide health, behavioral health, health/education services.
- Mutual respect, shared knowledge, communication re: areas of expertise.
- Electronic health records increases communication, decreases distance.

**Examples:**

- Urban/rural, hospital, community, school-based or primary care clinic: *Doctor/nurse practitioner, social worker, and health educator.*
- Community-based comprehensive multiservice centers: *Medical and dental, social workers, attorneys, educators, drug and outreach workers.*
- Intensive family support outreach team: *Social worker, psychologist, nurse, and child care worker, travel to rural communities (Charles and Alexander, 2014).*
Educational Seminars

- Seminars led by Multi-disciplinary University and agency leaders in Integrated Behavioral Health
- Expansion and Integration of ongoing learning in classroom and field
- Two each semester: University and Agency/Community-based
- Seminar Topics:
  - Integrated Health and The ACA: Life Span Developmental Approach
  - Stress and Childhood Obesity
  - Engaging High-Risk, Underserved Youth,
  - Preparing for your Job Search and Career in IYBH
  - Substance Use and Integrated Care in 2015
  - The Door: Comprehensive Services for Youth at Risk (Tour)
  - Transgender Youth: Assessment and Intervention
Collaboration with Field Partners

Active and ongoing collaboration with all levels of agency/organizational leaders

- Directors of organizations and programs on Advisory Board
- Educational Coordinators (EC) and Field Instructors (FI)
- EC’s and FI’s as partners in development of educational/training curriculum
- Agency leaders hosting Educational seminars
- Agency leaders as classroom instructors of Interprofessional Practice Elective

Training provided for Field Instructors

- Online Seminar in Field Instruction
Field Learning Practice Experience and Skills

Direct Practice:

- Screening and Assessment
- Risk-reduction and Health Promotion Counseling
- Individual short and longer-term intervention with youth
- Parent and Family Engagement, Assessment, Collaborative Counseling
- Groupwork: Psychoeducational; skill-based; counseling

Program and Community Development: Buenos Aires field sites

Interprofessional Practice:

- Interdisciplinary Teams with:
  - Medical providers—physicians, registered nurses, psychiatrists, speech therapists
  - Educators—Principals, teachers, psychologists
  - Health Educators
Specialized Core Content of Classroom, Field, and Seminars

- Academic, behavioral, social, community, and family influences on adolescent health
- Current urban issues that influence development and learning such as trauma, poverty, violence, homelessness, health, abuse and neglect, and substance abuse
- Understanding of contemporary health care reform policies including the Affordable Care Act
- Skills in engaging high-risk adolescents and their families
- Skills in screening and assessment for health, mental health, and substance use/abuse
- Individual, group, and family skills in evidence-based approaches to behavioral health concerns
- Skills in communication and leadership for practice within interprofessional teams of diverse healthcare, education, and social work professionals
Implications For Social Work Practice: Clinical and Interprofessional Practice Skills

Broad set of Clinical Practice skills:

- Culturally competent, person-in-environment and biopsychosocial assessment.
- Assessment/screening tools; brief behavioral interventions; evidence-based practices.
- Training in family systems: engagement, assessment, and intervention with parents and families.
- Knowledge about chronic illness, psychotropic medication, and sexuality.
- Skills in relaxation/mindfulness techniques.
- Provision of psychoeducation.
- Advocacy with interprofessional staff regarding behavioral/mental health and medical needs.
Implications For Social Work Practice: Clinical and Interprofessional Practice Skills

Broad set of Interprofessional Practice skills:

- Understanding of and genuine appreciation for the specific roles and functions of other professionals (medical doctors, nurse practitioners, nurses, physician assistants, drug counselors, health educators, psychiatrists, psychologists; principals, teachers, and other school staff; occupational, speech, and art therapists and other allied health professionals).

- Ability to clearly articulate and model the social work role within interprofessional collaborative relationships and teams.

- Team-based skills and ability to recognize and challenge hierarchical structures that present obstacles to effective collaboration.
Implications For Social Work Practice: Clinical and Interprofessional Practice Skills (Part 2)

Broad set of Interprofessional Practice skills:

- Skills in communication, problem-solving, and conflict management to collaborate effectively within interdisciplinary teams.

- Expertise in “tolerance for conflict, negotiation of boundaries, and willingness to confront competitiveness” (p. 630) within interprofessional teams (Pecukonis, Doyle, Acquavita, Aparicio, Gibbons, and Vanidestine, 2013).

- Effective skills in “curbside consultation,” brief, informal consultation with medical providers to help facilitate patient treatment (Horevitz and Manoleas, 2013).
HRSA INTEGRATED YOUTH BEHAVIORAL HEALTH PROGRAM:
Student Outcomes
2014-2017
Demographics

Cohort 1: 2014-2015
Cohort 2: 2015-2016
Cohort 3: 2016-2017

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Note
While there were 33 students in each cohort, not all completed the demographic surveys.
Bilingual Students

Cohort 2: 12 students
Cohort 3: 11 students

In summary: Of the 66 students in Cohorts 2 and 3, 35% self identified as bilingual

This item was not asked of the first cohort. The demographic section of the survey was re-written after AY 2014-2015.

Social Work Self-Efficacy Scale: Students were asked to rate their confidence in their ability to perform 59 behavioral health related services successfully.

Measurement: 5-level Likert Scale

(1 = I cannot do at all; 2 = I can do to a little extent; 3 = I can do to a moderate extent; 4 = I can do to a great extent; 5 = I can certainly do)
Social Work Self-efficacy (cont’d)

Cohort 1
• Pre-test mean: 3.54 (SD = .642)
• Post-test mean: 4.29 (SD = .440)
• Paired t-test: $P < .00$ ($\alpha = .05$)

Cohort 2
• Pre-test mean: 3.49 (SD = .622)
• Post-test mean: 4.33 (SD = .442)
• Paired t-test: $P < .00$ ($\alpha = .05$)

Cohort 3
• Pre-test mean: 3.21 (SD = .657)
• Post-test mean: 4.22 (SD = .539)
• Paired t-test: $P < .00$ ($\alpha = .05$)

Results: Statistically significant difference in cumulative pre- and post-scores
Transcultural self-efficacy (TSE)

http://www.springerpub.com/product/9780826117878

Transcultural Self-Efficacy Tool (TSE): Students’ knowledge was tested regarding working with clients of different cultural backgrounds (racial, ethnic, gender, socioeconomic, and religious differences). 3-Part Scale with subscales

*Measurement: 5-level Likert Scale (1 = Not at all confident; 2 = A little confident; 3 = Moderately confident; 4 = Highly confident; 5 = Totally confident)*
Transcultural self-efficacy (cont’d part 1)

Subscale 1: Students understand the ways cultural factors influence behavioral health

Cohort 1
- Pre-test mean: 2.95 (SD = .613)
- Post-test mean: 3.94 (SD = .709)
- Paired t-test: P < .00 (α = .05)

Cohort 2
- Pre-test mean: 3.06 (SD = .652)
- Post-test mean: 3.96 (SD = .493)
- Paired t-test: P < .00 (α = .05)

Cohort 3
- Pre-test mean: 2.59 (SD = .512)
- Post-test mean: 3.90 (SD = .537)
- Paired t-test: P < .00 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores
Transcultural self-efficacy (cont’d part 2)

Subscale 2: Students rate how confident they are interviewing clients of different backgrounds

Cohort 1
- Pre-test mean: 3.42 (SD = .690)
- Post-test mean: 4.11 (SD = .611)
- Paired t-test: P <.00 (α = .05)

Cohort 2
- Pre-test mean: 3.45 (SD = .686)
- Post-test mean: 4.19 (SD = .559)
- Paired t-test: P <.00 (α = .05)

Cohort 3
- Pre-test mean: 2.97 (SD = .647)
- Post-test mean: 3.93 (SD = .620)
- Paired t-test: P <.00 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores
Subscale 3: Students were asked to rate their confidence or certainly about their self-awareness

Cohort 1
- Pre-test mean: 4.00 (SD = .591)
- Post-test mean: 4.45 (SD = .474)
- Paired t-test: P = .007 (α = .05)

Cohort 2
- Pre-test mean: 4.27 (SD = .593)
- Post-test mean: 4.62 (SD = .522)
- Paired t-test: P = .005 (α = .05)

Cohort 3
- Pre-test mean: 4.01 (SD = .681)
- Post-test mean: 4.44 (SD = .730)
- Paired t-test: P = .023 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores
Transcultural self-efficacy (cont’d part 4)

Subscale 3A: Students were asked to rate their confidence or certainly about their awareness of different cultural backgrounds

Cohort 1
- Pre-test mean: 3.26 (SD = .936)
- Post-test mean: 4.96 (SD = .832)
- Paired t-test: P = <.00 (α = .05)

Cohort 2
- Pre-test mean: 3.23 (SD = .831)
- Post-test mean: 4.19 (SD = .604)
- Paired t-test: P = <.00 (α = .05)

Cohort 3
- Pre-test mean: 2.90 (SD = .840)
- Post-test mean: 3.95 (SD = .516)
- Paired t-test: P = <.00 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores
Transcultural Self-efficacy (cont’d part 5)

Subscale 3B: Students were asked to rate their acceptance of different cultural backgrounds

Cohort 1
- Pre-test mean: 3.98 (SD = .723)
- Post-test mean: 4.51 (SD = .555)
- Paired t-test: P = .007 (α = .05)

Cohort 2
- Pre-test mean: 4.19 (SD = .766)
- Post-test mean: 4.60 (SD = .528)
- Paired t-test: P = .015 (α = .05)

Cohort 3
- Pre-test mean: 4.05 (SD = .890)
- Post-test mean: 4.45 (SD = .606)
- Paired t-test: P = .071 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores for Cohorts 1 and 2 only
Transcultural Self-efficacy (cont’d part 6)

Subscale 3C: Students were asked to rate their *appreciation* of different cultural backgrounds

Cohort 1
- Pre-test mean: 4.19 (SD = .757)
- Post-test mean: 4.57 (SD = .597)
- Paired t-test: P = .029 (α = .05)

Cohort 2
- Pre-test mean: 4.28 (SD = .659)
- Post-test mean: 4.59 (SD = .466)
- Paired t-test: P = .027 (α = .05)

Cohort 3
- Pre-test mean: 4.19 (SD = .790)
- Post-test mean: 4.45 (SD = .686)
- Paired t-test: P = .203 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores for Cohorts 1 and 2 only
Transcultural self-efficacy (cont’d part 7)

**Subscale 3D: Students were asked to rate their recognition of different cultural backgrounds**

**Cohort 1**
- Pre-test mean: 3.50 (SD = .627)
- Post-test mean: 4.25 (SD = .946)
- Paired t-test: $P < .00$ ($\alpha = .05$)

**Cohort 2**
- Pre-test mean: 3.58 (SD = .779)
- Post-test mean: 4.34 (SD = .664)
- Paired t-test: $P < .00$ ($\alpha = .05$)

**Cohort 3**
- Pre-test mean: 3.52 (SD = .973)
- Post-test mean: 4.35 (SD = .584)
- Paired t-test: $P < .00$ ($\alpha = .05$)

**Results:** Statistically significant difference in cumulative pre- and post-scores
Transcultural self-efficacy (TSE) (cont’d part 8)

Subscale 3E: Students were asked to rate their advocacy for persons of different cultural backgrounds

Cohort 1
- Pre-test mean: 3.66 (SD = .955)
- Post-test mean: 4.16 (SD = .723)
- Paired t-test: P = .024 (α = .05)

Cohort 2
- Pre-test mean: 3.66 (SD = .860)
- Post-test mean: 4.35 (SD = .767)
- Paired t-test: P = .003 (α = .05)

Cohort 3
- Pre-test mean: 3.73 (SD = .898)
- Post-test mean: 4.43 (SD = .568)
- Paired t-test: P = .002 (α = .05)

Results: Statistically significant difference in cumulative pre- and post-scores
Mastery


**Mastery Scale:** Students were asked to measure the extent they see themselves in control of forces that affect their lives.

**Measurement:** 4-level Likert Scale (*1 = Strongly Disagree; 2 = Strongly Agree; 3 = Agree; 4 = Strongly Agree*)
Mastery (cont’d)

Cohort 1
- Pre-test mean: 4.11 (SD = .546)
- Post-test mean: 4.16 (SD = .643)
- Paired t-test: P = .747 (α = .05)

Cohort 2
- Pre-test mean: 4.15 (SD = .452)
- Post-test mean: 4.26 (SD = .487)
- Paired t-test: P = .227 (α = .05)

Cohort 3
- Pre-test mean: 4.09 (SD = .480)
- Post-test mean: 4.22 (SD = .402)
- Paired t-test: P = .343 (α = .05)

Results: NO statistically significant difference in cumulative pre- and post-scores
Evidence-based Practice Attitude (EBPAS)


Evidence-Based Practice Attitude Scale: Students were asked about their feelings using new types of therapy, interventions, or treatments. Three subscales.

Measurement: 5-level Likert scale (1 = Not at all; 2 = To a slight extent; 3 = To a moderate extent; 4 = To a great extent; 5 = Certainly)
Evidence-based Practice Attitude (cont’d part 1)

Subscale Openness: Students were asked to rate their openness to try new interventions, etc.

Cohort 1
- Pre-test mean: 4.14 (SD = .751)
- Post-test mean: 4.33 (SD = .646)
- Paired t-test: P = .27 (α = .05)

Cohort 2
- Pre-test mean: 4.08 (SD = .681)
- Post-test mean: 4.28 (SD = .670)
- Paired t-test: P = .190 (α = .05)

Cohort 3
- Pre-test mean: 4.15 (SD = .690)
- Post-test mean: 4.28 (SD = .700)
- Paired t-test: P = .965 (α = .05)

Results: NO statistically significant difference in cumulative pre- and post-scores
Evidence-based practice attitude (cont’d part 2)

Subscale Divergence: Students were asked to rate their divergence towards new interventions, etc.

Cohort 1
- Pre-test mean: 1.76 (SD = .518)
- Post-test mean: 2.09 (SD = .913)
- Paired t-test: $P = .10$ ($\alpha = .05$)

Cohort 2
- Pre-test mean: 1.79 (SD = .529)
- Post-test mean: 2.01 (SD = .657)
- Paired t-test: $P = .100$ ($\alpha = .05$)

Cohort 3
- Pre-test mean: 1.76 (SD = .498)
- Post-test mean: 1.96 (SD = .648)
- Paired t-test: $P = .252$ ($\alpha = .05$)

Results: NO statistically significant difference in cumulative pre- and post-scores
Evidence-based practice attitude (cont’d part 3)

Subscale Appeal: Students were asked to rate the likelihood of trying new interventions, etc., based on interventions’ appeal.

Cohort 1
- Pre-test mean: 4.01 (SD = .751)
- Post-test mean: 4.19 (SD = .638)
- Paired t-test: P = .26 (α = .05)

Cohort 2
- Pre-test mean: 3.76 (SD = .789)
- Post-test mean: 3.97 (SD = .779)
- Paired t-test: P = .179 (α = .05)

Cohort 3
- Pre-test mean: 3.71 (SD = .923)
- Post-test mean: 4.08 (SD = .589)
- Paired t-test: P = .095 (α = .05)

Results: NO statistically significant difference in cumulative pre- and post-scores
Evidence-based practice attitude (cont’d part 4)

Subscale Require: Students were asked to rate likelihood of trying new interventions, etc. based on if they were required.

Cohort 1
- Pre-test mean: 4.18 (SD = .980)
- Post-test mean: 3.94 (SD = .900)
- Paired t-test: P = .56 (α = .05)

Cohort 2
- Pre-test mean: 3.95 (SD = .870)
- Post-test mean: 3.88 (SD = 1.13)
- Paired t-test: P = .830 (α = .05)

Cohort 3
- Pre-test mean: 3.79 (SD = .986)
- Post-test mean: 3.76 (SD = 1.07)
- Paired t-test: P = .924 (α = .05)

Results: NO statistically significant difference in cumulative pre- and post-scores
Video simulation

Focus groups: May 2015
Graduating Student Surveys: 2016 and 2017
Advisory Board Meeting: Spring 2015

Result: Students and field instructors asked for more content related to “difficult” clinical situations such as a suicidal or homicidal client
Video Simulation Part 2

Advisory Board Meeting: December 2015 - (Former) Dean Lynn Videka proposed idea of creating video simulations that would illustrate how a difficult clinical situation would be assessed and treated in an Integrated Behavioral Health setting

Video Subgroup Created
• First meeting: April 2016 – focused on ideas for video simulations with input from Elizabeth McAlpin, Assistant Director of Learning and Curricular Development.
• Second meeting: May 2016 – Case scenario established
• Third meeting: June 2016 – Review of process recordings for script development. Scriptwriting group formed

Script development: August 2016
Video Simulation Part 3

Video Subgroup October 2016 meeting – review of script with assistance from Elizabeth McAlpin, Assistant Director of Learning and Curricular Development, Global Learning and Innovation, Hugh Mackey (Media Production Team Lead) and Lillian Moran (Educational Design Technologist)

October to January

- Secure Recording space – The Door
- Hire actors – all people of color
- Site scouting by camera crew

January 5, 2017: Final script read-through with actors
January 28, 2017: Taping
January – April: Film editing, captions, and credits
Video Simulation Part 4
Websites

American Academy of Child and Adolescent Psychiatry. (http://www.aacap.org)


Massachusetts Department of Public Health Bureau of Substance Abuse (2009). Provider guide: Adolescent screening, brief intervention, and referral to treatment for alcohol and other drug use. (goo.gl/zDNGQh)

National Institute of Mental Health (https://nimh.nih.gov)

Rapid Assessment for Adolescent Preventive Services RAAPS (2016): (http://www.raaps.org/recommendations)


The Center for Adolescent Substance Abuse Research (2016). The CRAFFT Screening Tool. (http://www.childrenshospital.org/ceasar/crafft)

The National Child Traumatic Stress Network, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services. (http://www.nctsnet.org)

Trauma Institute and Child Trauma Institute (http://www.childtrauma.com)
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