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Behavioral Health Crisis Intervention for Emergency Department Patients Pending Psychiatric Hospitalization

by

Colten Wayne Larsen

Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

December 15, 2020

Behavioral Health Crisis Intervention for Emergency Department Patients Pending Psychiatric Hospitalization

by

Colten Wayne Larsen

has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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Behavioral Health Crisis Intervention for Emergency Department Patients
Pending Psychiatric Hospitalization

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Abstract

Emergency departments (EDs) are often the first access point to services for suicidal patients (Miller et al., 2017) and assessment of risk. Suicide has become the second-most common cause of death for Americans, yet those at the most risk often have limited access to appropriate care. In addition, suicidal patients spend more time in the ED than those with other presenting problems. Compounding the problem is these patients who have the longest length of stay are medically stabilized but don't receive treatment interventions related to their presenting problem. Together, these findings indicate a need for accessible intervention in the ED. This study is a program development of an intervention protocol and training designed to initiate treatment for behavioral health problems in the ED. The program's goal is to provide services for individuals still actively suicidal or at high-risk but waiting in the ED for psychiatric hospitalization. Training outcome results indicate an overall significant improvement in trainee competency and comfort in administering the intervention protocol, as well as a large effect size, indicating more robust generalizability in other settings. However, analysis indicates some

discrepancies in competency areas, warranting future training improvements. Results, limitations, and considerations for future research are also discussed.

Keywords: program development, program evaluation, program implementation, suicide, suicide prevention, suicide intervention, suicide treatment, EPIS model, behavioral health, mental health, psychology, emergency department, length of stay, acceptance and commitment therapy

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Chapter 1

Introduction

Time and awareness have yielded growing evidence of the utility of integrated behavioral health within a medical system (Auxier et al., 2013). Integrated behavioral health has been implemented in a variety of contexts, with the help of a wide range of mental health professionals. Social workers, master's level therapists, and licensed psychologists are only some of the behavioral health professionals who have been integrated into a medical setting in order to address growing concerns regarding behavioral health disorders in the general population (Belar, 2012; Bryan et al., 2009). Likewise, this integration has promoted the availability of behavioral health services to a population who may otherwise not receive treatment (Da Cruz et al., 2011; Steel et al., 2006).

Despite the growing number of behavioral health services integrated into various medical system contexts, effectiveness of treatment in some of these contexts has yet to be explored. Specifically, there is a lack of research in the development and implementation of behavioral health intervention within general hospital emergency departments (EDs; Miller et al., 2017), where patients present in the midst of behavioral health crisis related to suicidality or failed suicide attempt. In fact, the ED is the first point of contact that many suicidal individuals have with behavioral health providers, making ED visits a prime opportunity for intervention (Boudreaux et al., 2013). A limited number of behavioral health facilities provide emergency psychiatric services (EPS), typically only specialized environments within a greater inpatient

system and less accessible to those outside the vicinity of the available services. Incorporating brief behavioral health interventions within a general hospital ED provides an opportunity to initiate foundational treatment (e.g., emotional regulation) while waiting for placement. This present study is a program evaluation utilizing the first two phases of a program evaluation logic model of integrated behavioral health services in a general hospital ED, and the scope of this project was to design an intervention protocol, train medical team staff on implementation, and measure the outcome of the training.

Background

The Problem—Suicidality and Behavioral Health Intervention

Suicide has become the second-most common cause of death for Americans, with the highest risk between ages 15 and 35 (CDC, 2018). In Oregon, the suicide rate has seen a steady increase since 2009 (Oregon Vital Statistics). Yet, expedient access to behavioral health care has continued to be a problem in the United States, particularly for youth, older adults, the homeless, and those in smaller, rural areas (Michelen et al., 2006). National decades-long shifts to community-based behavioral health care have meant shifts away from institutional care, leaving few psychiatric inpatient options for behavioral health crisis. A 2014 report by the United States Department of Justice on Oregon's mental health services stated that Oregon "is not yet providing an adequate array or volume of services in the community." (U.S. Dept. of Justice, 2014).

Related to deinstitutionalization and the lack of community-based care options, those with severe needs such as suicidality have limited access to appropriate care (psychiatric hospitalization), so are admitted to general hospital EDs. In many cases, suicidal patients stabilize (active suicidality wanes) before inpatient psychiatric admission is achieved (in this

sample, waiting time for admission were between 3 and 12 days). In these situations, patients are discharged to routine outpatient care. However, suicidality is not typically a fleeting, momentary condition, so recurrence is more often the norm. For those that are discharged without inpatient psychiatric hospitalization, there are very few psychiatrists in Oregon (Hawryluk, 2016), and existing ones rarely take new patients. For them, it's just a matter of time before symptoms return and patients are readmitted to the ED. At the small, rural hospital in this study, suicidal patients stay in a monitored and secure room with bare walls and simple furnishings (a hospital bed and a chair). While patients are re-assessed every 12 hours (and sometimes dosed with benzodiazepines), no behavioral health intervention is offered during the extended hospitalization wait time. Although no interventions are typically offered, research has shown (Robinson & Reiter, 2016) that very brief interventions may be an effective way to begin treatment. Brief interventions can positively impact patient mood or thoughts, while also illustrating the benefits of behavioral health interventions which may subsequently affect follow-up in ongoing care (Robinson & Reiter, 2016). While many EDs are taking the initiative to decrease readmission of individuals presenting with active suicidality, the number of general hospital EDs effectively addressing this issue are still minimal (Petrik et al., 2015). Similarly, individuals experiencing severe, persistent mental illness and/or suicidality spend more time in the ED due to a lack of resources and hospitals available to provide the necessary interventions (Southard et al., 2014).

Related to the concerns outlined above, the aims of this study are to complete a program development and evaluation of a rural community hospital's ED care for patients who present with psychiatric concerns including suicidality. This hospital has seen increased ED visits related to psychiatric concerns, and has implemented minimal intervention up to this point, having

operated instead as a place of medical stabilization until a psychiatric hospital admission could be completed. This study seeks to describe the utility and application of a logic model in developing and evaluating a new intervention program. Next, this study aims to effectively apply a logic model in the development and evaluation of a proactive intervention plan for individuals in general hospital EDs who are awaiting admission to psychiatric hospitalization.

Program Evaluation Model

Program evaluation has been defined as “a process of examining objectives or intents of a program and then determining whether the performance of interventions is congruent with those objectives or intents” (Murphy et al., 2018). While typical research seeks to prove or disprove a hypothesis, evaluation of a program is often used to justify the effectiveness of a newly developed or older program. Program development and evaluation has even been described as an ethical obligation of mental health providers, promoting more effective and sustainable programs and interventions (Forrester, 2012).

While there are many theories and approaches to program evaluation, logic models have become a popular framework in the development and evaluation of new programs (Kneale et al., 2015). The Centers for Disease Control and Prevention (CDC) describes a logic model as “a graphic depiction (road map) that presents the shared relationships among the resources, activities, outputs, outcomes, and impact for a program. It depicts the relationship between a program’s activities and its intended effects” (Framework for Program Evaluation, 2018). In a field where the challenge is to develop effective Evidence-Based Practices (EBPs) within public health, the use of tested frameworks, models, and theories is crucial (Moullin et al., 2019).

EPIS Logic Model

One specific logic model that has proven to be effective in the development and evaluation of programs within mental health is the Exploration, Preparation, Implementation, and Sustainment (EPIS) model (see Figure 1). The EPIS model is a framework that has been applied in public sector social and allied health service systems in the US (Moullin et al., 2019). As its name depicts, the Exploration phase is when stakeholders, or the party with the concern, recognizes the need for better or new health needs for patients. Likewise, this phase also includes exploration of EBPs and potential EBP adaptations for the system. Second, the Preparation phase involves "identifying potential barriers and facilitators of implementation, further assess needs for adaptation, and to develop a detailed implementation plan to capitalize on implementation facilitators and address potential barriers," (Moullin et al., 2019). Preparation is also the phase in which preparation for training and feedback takes place.

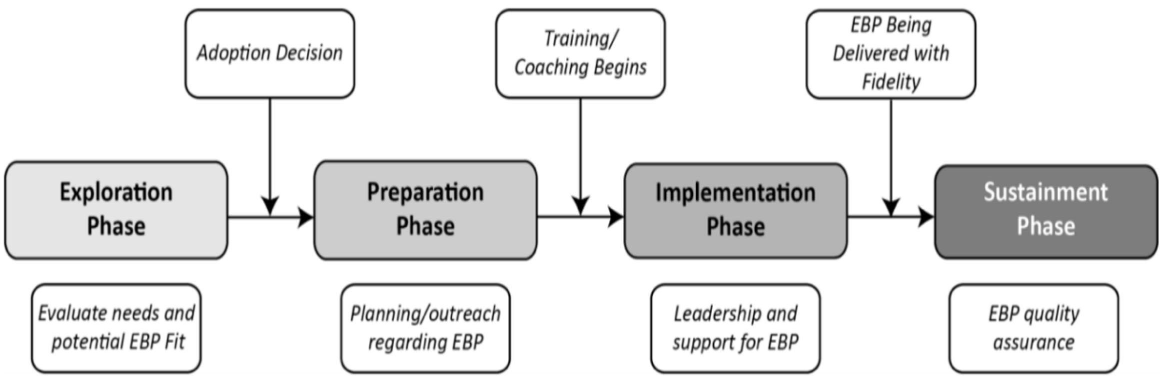
Following the first two phases is the Implementation phase. Within this phase, the prepared plan is set into motion, including monitoring progress, and initiating the proposed plan. Finally, Sustainment takes place, which is the process of supporting the program, as well as adapting when necessary (Moullin et al., 2019). In this study, the EPIS model serves to simplify and systematize the process of change in complex ED systems with many stakeholders, considering the needs of both the patients and the system serving them.

Study Site

Providence Newberg Medical Center (PNMC) is a general medical center run by Providence Health and Services, a not-for-profit network of hospitals, health plans, physicians, clinics, and other health services across the western United States. PNMC is a Type B hospital (fewer than 30 beds, located within 30 miles of another hospital) and a sole community hospital

Figure 1

*The *EPIS Logic Model*



Note. *From Aarons et al. (2011).

(rural hospital, no more than 25% of Medicare beneficiaries are admitted to other like hospitals) (Oregon Health Authority, 2018). This rural community hospital has a medical/surgical unit (27 beds), intensive care unit (4 beds), a birth center, a Level IV acute care emergency department (15 beds), three operating rooms, a sleep apnea laboratory, and a general medicine department. In regard to psychiatric referrals in the ED, preliminary data analyzed included demographics from child/adolescent and adult behavioral health ED visits initiated after hours (from 5 PM to 8:30 AM on weekdays), and on weekends and holidays, in one rural hospital, from 2013 to 2017. In total, 239 visits were included. Trends were analyzed regarding year, age, ethnicity, gender, SES, and diagnostic group.

Statistics

Of the youth visits, the highest risk age presenting to the ED for suicidality was 15 years (31.6%), followed by ages 16, 14, and 13 respectively. In regard to ethnicity, visits have increased by racial/ethnic minorities in the last six years, with minority adolescents at higher risk

than white adolescents, when controlling for population density. Gender trends indicate that females were at higher risk than males (72.4% and 25.5%, respectively; 2% transgender). Socioeconomic trends (approximated by private versus no insurance/state insurance) indicated that adolescents who had state insurance were at higher risk than those with private insurance when controlling for population density (34.7% compared to 37.7% of the US population and 32.7% compared to 67.2% of the US population, respectively). Finally, mood disorders (65.3%), anxiety disorders (19.9%), and adjustment problems (4.6%) made up a large majority of primary diagnoses. For those awaiting hospitalization, youth spent 12 hours to 12 days in the ED. For those pending placement, length of stay was 17 hours on average before being discharged either to outpatient care or inpatient psychiatric hospitalization. Ten percent of the adolescent patients spent over 36 hours in the ED.

Of adult visits, age and rate of presentation to the ED for suicidality were negatively correlated. Data indicated that females were more likely to utilize the ED for suicidality (59.9%) as compared to males (39.6%). Similar to adolescents, adults with lower socioeconomic status were also more likely to utilize the ED for crisis (private insurance, 26.1%, versus state or other insurance, 35.4% and 38.5%, respectively). Mood disorders (59.4%) and anxiety disorders (14.6%) were amongst the primary diagnoses for those presenting with suicidality in the ED. In regard to ethnicity, those of European heritage were the most likely to utilize ED services (83.8%), as compared to Latin-x (7.8%) and African American (2.2%). The average length of stay for adults was 22 hours, and the population proportions of hours spent in the ED were as follows: 12 hours or less (56.6%), 12-24 hours (19%), 24-36 hours (7.1%), 36-48 hours (5.2%), 48-72 hours (5.9%), 72 to 96 hours (2.2%), 96 to 120 hours (1.2%), 120 to 144 hours (0.9%), 144 to 168 hours (0.6%), 168 to 192 hours (0.5%), 192 to 216 hours (0.2%), 216 to 240 hours

(0.3%), 240 to 264 hours (0.2%), 264 to 288 hours (0.1%). In sum, these preliminary data seek to characterize trends in suicidality as part of designing intervention for emergency department utilization.

Due to the increased rates of suicidality in patients presenting to the ED, and lengthy stays before psychiatric placement can be completed, the hospital has sought coordination with behavioral health providers, and has worked to address the increased prevalence and severity of suicidality. Hospital administrators and staff reported interest in an efficient, accessible, and flexible program to help address the increased suicidality in the ED. Behavioral health providers involved in the program implementation include the Behavioral Health Crisis Consultation Team (BHCC). This team, comprised of supervised master's level clinical psychology doctoral students, aid in the assessment of high-risk patients presenting within the ED. As part of the interdisciplinary team, the BHCCs provide consultation with medical staff and risk assessments regarding suicidal, homicidal, and psychotic patients.

Chapter 2

Methods

The first two stages of the EPIS program evaluation model are used as a framework for developing and evaluating the intervention program within the emergency department (ED) at Providence Newberg Medical Center. In collaboration with an interdisciplinary team of medical providers, doctoral psychology students and clinicians, and undergraduate psychology students, this project involved designing an intervention appropriate to the needs of the setting and training the medical team to implement it. The program developed will be overseen by the Behavioral Health Crisis Consultation Team composed of contracted master's level PsyD students, as well as ED nursing staff. Additionally, the program utilizes undergraduate students as constant observers (COs) of high-risk patients who also administer brief psychological interventions to patients awaiting hospitalization. The program's goal is to provide services for individuals who are still actively suicidal or at high-risk but are waiting in the ED for psychiatric hospitalization. The proactive program includes: (a) easily accessible, evidence-based Acceptance and Commitment Therapy (ACT) interventions and mindfulness relaxation, (b) improved communication between medical health providers and behavioral health providers, and (c) training opportunities for undergraduate and graduate students interested in integrated care and high-risk populations.

Phase 1: Exploration

At the program exploration phase, evidence-based treatments and other necessary resources, such as training effectiveness and satisfaction measures, were secured to allow for efficient program launching. Specifically, the program supervisor and project manager were engaged in establishing the needs and objectives, as well as strategies, in order to address the concerns raised by hospital officials. This process involved preliminary exploration of the specific needs of the ED, easy to follow intervention techniques and materials, and patients who would benefit the creation of the project.

Intervention

In order to design the intervention, research on evidence-based intervention in suicidality was reviewed. Concepts were drawn from Acceptance and Commitment Therapy, a third-wave cognitive behavioral therapy.

Cognitive behavioral therapy can be identified as a particular group of theories and interventions that address core aspects of a person's psychological functioning: behavior, thoughts, and emotion. As this psychological theory has developed over the years, different "waves," or eras, have taken place. The first wave is best identified by the orientation of addressing the behavioral aspect of a person's functioning, while the second wave focused more on thoughts and how thoughts can affect behaviors and emotions. Today, third wave CBT has become a popular theoretical orientation amongst practicing clinicians. This wave is "based on contextual concepts focused more on the persons' relationship to thought and emotion than on their content," (Hayes & Hofmann, 2017). One third-wave CBT approach, Acceptance and Commitment Therapy (ACT), is an action-oriented approach to psychotherapy that builds on principles from traditional behavior therapy and cognitive behavioral therapy. The goal of ACT

is for a person to stop denying, avoiding, and struggling with the emotions experienced and, in turn, begin to accept the feelings they are experiencing. Through ACT, the person comes to the realization that emotions are appropriate and acceptable given the circumstance the person is experiencing. Simply put, “Clients begin to accept their issues and hardships and commit to making necessary changes in their behavior, regardless of what is going on in their lives, and how they feel about it” (Acceptance and Commitment Therapy, n.d.)

In a study conducted by the Department of Psychiatric Emergency and Acute Crisis, Academic Hospital of Montpellier, France, it was found that the ACT approach to suicidality could be an effective treatment to suicidal ideation amongst patients in crisis. Specifically, it was found that ACT would increase change in the patient’s relationship to their internal experiences, clarify what is really important in their life, increase the meaning of existence through personal engagement toward value-oriented actions, and impact modifiable suicidal risk factors such as “hopelessness, psychological pain, and quality of life” (Ducasse et al., 2014).

Regarding suicide prevention, another study was conducted which looked at the effectiveness of ACT-based treatment as a preventative measure for suicidality. It was found that ACT intervention significantly raised self-efficacy and found suicidal prevention behaviors, along with trends in increased knowledge and decreased stigma regarding the subject (Bazley & Pakenham, 2019). Another study (Walser et al., 2015) demonstrated the utility of ACT-based treatment for depression in veterans. It was concluded that the interventions were effective in reducing depression, as well as suicidal ideation (Walser et al., 2015). Based on current research, ACT was determined to be an easily accessible, evidence-based treatment for those awaiting psychiatric hospitalization within the ED.

Structured Expectations and Reinforcers

In addition to involving evidence-based strategies in the intervention, the medical teams indicated that one of the ongoing concerns is high-utilizers and the potential for over-utilization of ED services by individuals who presented repeatedly, on multiple occasions. The medical teams voiced an intent to strike a balance between effective care and maladaptive reliance on the ED setting for coping. To address this concern, standardized and structured expectations to be implemented with consistency across medical staff were developed, including the use of contingent reinforcers for compliance with the intervention protocol.

Specifically, two concepts were used to formulate a reward system in compliance with interventions within the ED. Utilizing behavioral activation (BA), interventions are used to change the patients' negative cycle of maladaptive thoughts and behaviors by replacing or changing their behaviors. The aim is to explore the patient's actions in relation to his or her environment. The avoidance of certain actions, and the simultaneous avoidance of negative or otherwise uncomfortable feelings, can result in negative consequences and exacerbate depressive symptoms. BA focuses on helping the patient change this negative circle by changing his or her behavior (Walser et al., 2015). To motivate behavioral activation and positive affect, contingent reinforcers were utilized (Gill et al., 2017). These reinforcers were tied to privileges given to the patient if they participated in intervention or not. These rewards are described further in the preparation phase.

Phase 2: Preparation

In the initial preparation phase, administrators facilitated meetings with hospital officials, as well as meetings with the different teams in order to outline concerns and possible solutions. The scope of the project was four-point and included, (a) developing the intervention protocol,

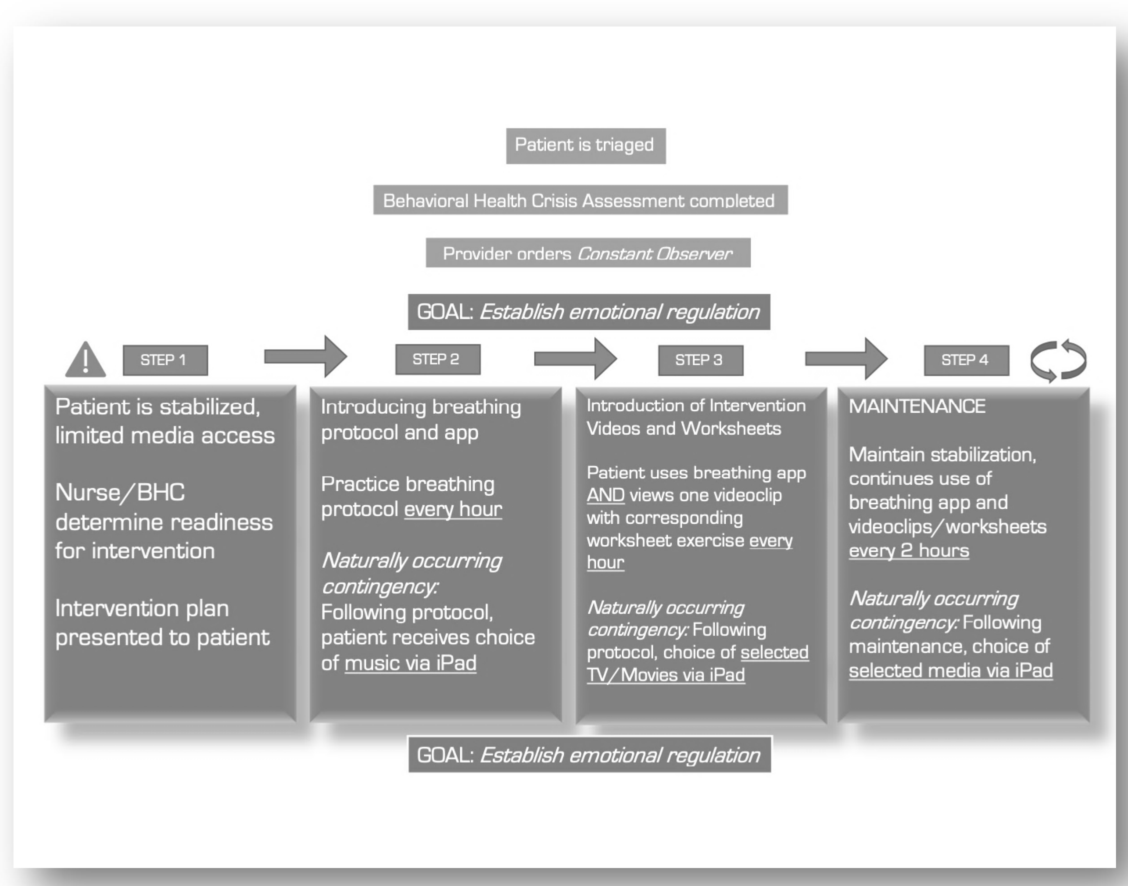
(b) training undergraduate psychology students as constant observers who could facilitate implementation of the intervention protocol, (c) training for hospital staff and BHCC team, and (d) development of outcome measures. A team of doctoral students was assigned to each of these points, with the significant involvement of the principal researcher.

Intervention Protocol

An easy-to-follow intervention protocol was developed to be implemented by undergraduate constant observers. This protocol included a step-by-step guide outlining the intervention process (see Figure 2 and Appendix B).

Figure 2

ED Intervention Process and Level of Care



Additionally, the protocol development process included putting together a list of ACT intervention videos and corresponding worksheets as components that could be selected in the intervention process (Russ, n.d.). Additionally, a breathing and meditation relaxation app, "Calm," was added to the protocol as a starting point for intervention. This app was chosen based on its applicability and ease of use, as well as popularity on iTunes and Android application platforms and in studies examining the effectiveness of mindfulness apps (Mani et al., 2015). The app provides simple breathing intervention by having the person follow along mindful breathing with visual stimuli for approximately 3-5 minutes.

The step-by-step guide for intervention protocol includes four steps of intervention, based on the receptiveness of intervention by the patient. Once a patient is awaiting psychiatric hospitalization, Step 1 is implemented. In this step, the patient is stabilized and their access to media, including tablets and cell phones, is limited. The charge nurse and/or crisis consultant then determine readiness for intervention, based on the patient's ability to engage in coherent conversation and follow simple instruction. If the patient is determined to be ready, Step 2 is implemented. Step 2 introduces the Calm breathing app in which the patient participates in the practice for 5-minute intervals every hour. Following compliance of the breathing exercise, the patient is rewarded with their choice of music. Once the patient successfully engages in the breathing exercise three times (consecutively), the patient moves to Step 3. In this step, the patient is presented the breathing exercise followed by a videoclip introducing an ACT intervention concept (See Appendix C). Once the video is completed, the patient is provided a worksheet with corresponds to the video and allows them to apply the concepts to their own lives. After two consecutive completions of this step, the patient is rewarded with their choice of select TV shows and/or streamed movies. Compliance with intervention participation (i.e., Step

4, Maintenance) continues every three hours until the patient is transferred to an available psychiatric hospital or discharged from the hospital after stabilization and safety is established.

Undergraduate Constant Observer Training

Following the development of the intervention protocol, the undergraduate constant observer training process included creating a simplified, easy-to-follow training for undergraduate constant observers (See Appendix A). This training covered topics such as the understanding of suicidality, homicidality, and psychosis, as well as understanding of the hospital system and respective roles within the ED. Additionally, due to hospital and university concerns of undergraduate student contact directly with patients, the interventions and protocols were streamlined to a no-contact format by utilizing Apple iPads, Apple TV, and screen projection. To aid in this, visual instructions, which can be projected onto the TV within the patient's room, were also created for the patients to review prior to the start of any intervention step (See Appendix B). Those who participated in the training were 72% European-American, 11% Latin-x or Hispanic, 6% Asian descent, and 11% other.

Medical Staff Training

Additionally, a simplified training was created for the Behavioral Health Crisis Team and nursing staff in order to explain the new program and the respective roles of these professionals in the initiation stages of the protocol. Part of the training was also to ensure consistency in responding to patients. Due to the wide range of interdisciplinary professionals in contact with the patients at any given time, providing a consistent approach in protocol ensures reduced likelihood of missed intervention responsiveness.

Outcome Measures

Pre- and post-training measures were then developed, in order assess training effectiveness and outcomes. The measure used to assess undergraduate constant observer competency was based on The American College of Healthcare Executives (ACHE) Healthcare Executive Competencies Assessment Tools (Garman & Tran, 2006). This measure was revised to accommodate the specific aspects of this program (See Appendices D & E). Competency topics covered in the specific items used in the pre- and post-training measures includes communication and relationship management, leadership, professionalism, knowledge of the healthcare environment, and business skills and knowledge.

A second outcome measure was developed to assess satisfaction of ED staff with the new program (See Appendices F & G). The satisfaction measure was created and shaped to meet the needs and concerns of the hospital. Both measures also included open-ended questions pertaining to the evaluation of the training process, suggestions for improvement, as well as demographic information for analysis.

Chapter 3

Results

Reliability of Training Measures

The overall value of the Cronbach's α for the pre-measure was .95, which is considered adequate, as was the post-measure Cronbach's α, which was .94. Regarding the program improvement questions, the value of the Cronbach's α was .83.

Normality of Training Measure Items

The Statistical Package for the Social Sciences (SPSS, version 26.0) was used for all analyses. Normality of the variables was explored using Shapiro-Wilk Test of Normality, and results are displayed in Table 1.

Table 1

Descriptives

Item	Median	SD	Shapiro-Wilk p-value (Normality)
Item 1 Pre	4	0.79	0.01
Item 2 Pre	4	0.97	0.01
Item 3 Pre	3	1.18	0.07
Item 4 Pre	4	0.87	0.00
Item 5 Pre	4	0.58	0.00
Item 6 Pre	4	0.69	0.00
Item 7 Pre	4	0.87	0.00
Item 8 Pre	3	0.98	0.06

Item	Median	SD	Shapiro-Wilk p-value (Normality)
Item 9 Pre	3.5	0.91	0.02
Item 10 Pre	4	0.79	0.01
Item 11 Pre	4	1.10	0.00
Item 12 Pre	4	0.79	0.00
Item 13 Pre	4	0.86	0.02
Item 14 Pre	4	0.87	0.01
Item 15 Pre	4	1.24	0.04
Item 16 Pre	3	0.88	0.01
Item 17 Pre	3	0.99	0.01
Item 18 Pre	4	0.61	0.00
Item 19 Pre	3.5	0.70	0.00
Item 20 Pre	3	0.96	0.00
Item 21 Pre	3.5	0.98	0.02
Item 22 Pre	3.5	1.10	0.01
Item 23 Pre	3	1.30	0.04
Item 24 Pre	3	1.16	0.16
Item 25 Pre	3	1.11	0.01
Item 26 Pre	3.5	1.17	0.04
Item 27 Pre	4	1.41	0.00
Item 28 Pre	3	1.23	0.09
Item 29 Pre	4	1.10	0.01
Item 30 Pre	3	1.04	0.06
Item 1 Post	4	0.64	0.00
Item 2 Post	4	0.71	0.00
Item 3 Post	4	1.03	0.00
Item 4 Post	4	0.86	0.01
Item 5 Post	4	0.43	0.00
Item 6 Post	4	0.71	0.00

Item	Median	SD	Shapiro-Wilk p-value (Normality)
Item 7 Post	5	0.71	0.00
Item 8 Post	4	0.65	0.00
Item 9 Post	4	0.73	0.00
Item 10 Post	4	0.73	0.00
Item 11 Post	4	0.96	0.02
Item 12 Post	4	0.58	0.00
Item 13 Post	4	0.75	0.00
Item 14 Post	4	0.69	0.00
Item 15 Post	4	0.91	0.00
Item 16 Post	3	0.92	0.03
Item 17 Post	4	0.67	0.00
Item 18 Post	5	0.49	0.00
Item 19 Post	4	0.65	0.00
Item 20 Post	4	0.86	0.00
Item 21 Post	4	0.92	0.03
Item 22 Post	4	0.90	0.00
Item 23 Post	4	1.09	0.02
Item 24 Post	4	1.04	0.05
Item 25 Post	4	1.18	0.01
Item 26 Post	4	0.58	0.00
Item 27 Post	5	0.62	0.00
Item 28 Post	4	1.03	0.01
Item 29 Post	4	0.80	0.00
Item 30 Post	4	0.92	0.05
Improvement Item 1	4.5	.514	0.00
Improvement Item 2	4.5	.778	0.00
Improvement Item 3	4.5	.616	0.00
Improvement Item 4	4	.608	0.00

Item	Median	SD	Shapiro-Wilk p-value (Normality)
Improvement Item 5	5	.502	0.00
Improvement Item 6	4	.608	0.00
Improvement Item 7	5	.461	0.00
Improvement Item 8	4	.900	0.03
Improvement Item 9	4	.511	0.00
Improvement Item 10	4	.686	0.00

Pre- and Post-Test Comparisons

Analyses focused on the outcomes of the undergraduate CO training using pre- and post-training outcome measures. Because normality assumptions were not met for item comparisons, nonparametric tests were used (Wilcoxon Signed-Rank Tests). However, total scores met normality assumptions, so total score comparisons were completed using a Repeated Measures T-Test. A significant difference was found between pre-test total scores (M = 107.13, SD = 17.53) and post-test total scores (M = 124.69, SD = 13.67). This improvement was statistically significant, $t(15) = -5.65$, $p = 0.002$, $D = 1.12$, power = .99).

Next, pre- and post-test item differences were explored using Wilcoxon Signed-Rank Tests. These results are shown in Table 2.

Table 2

Single Item Pre – Post Wilcoxon Signed-Rank Tests

Item	n	*W*	Std Error	*p*	*r*
Item 1: Organizational structure and relationships	18	21	4.7	0.03	-0.372
Item 2: Demonstrate effective interpersonal relations	18	24	6.63	0.37	-0.151
Item 3: Identify stakeholder needs/expectations	17	78	12.28	0.00	-0.546

Item	n	*W*	Std Error	*p*	*r*
Item 4: Sensitivity to what is appropriate behavior when communicating with diverse cultures, both internal and external	17	4.5	1.84	0.41	-0.189
Item 5: Receive constructive feedback	18	36	6.63	0.01	-0.542
Item 6: Adhere to legal and regulatory standards	18	20	5.29	0.26	-0.189
Item 7: Foster an environment of mutual trust	18	32.5	6.82	0.03	-0.354
Item 8: Explore opportunities for the growth and development of the organization on a continuous basis	18	73.5	12.28	0.01	-0.468
Item 9: Anticipate and plan strategies for overcoming obstacles	18	66	10.91	0.00	-0.504
Item 10: Patient's rights and responsibilities	18	67	11.91	0.02	-0.392
Item 11: Consequences of unethical actions	18	45	9.01	0.05	-0.324
Item 12: Professional roles, responsibility, and accountability	18	21	4.62	0.02	-0.379
Item 13: Professional standards and codes of ethical behavior	18	40.5	7.79	0.02	-0.385
Item 14: Uphold and act upon ethical and professional standards	18	32	6.63	0.04	-0.352
Item 15: Adhere to ethical business principles	18	30	6.93	0.08	-0.289
Item 16: Healthcare and medical terminology	18	45	9.01	0.05	-0.324
Item 17: Physician, nurse, and BHCC roles	18	120	17.32	0.00	-0.577
Item 18: Constant Observer roles	18	24	5.29	0.06	-0.315
Item 19: The patient's perspective (e.g., cultural differences, expectations, psychopathology, etc.)	18	51	9.42	0.01	-0.416
Item 20: Organization and delivery of healthcare	18	75	12.37	0.00	-0.485
Item 21: Standards of care	17	50	12.31	0.37	-0.149
Item 22: Evidence-based practice	18	78	12.31	0.00	-0.528
Item 23: Medical staff structure and its relationship to the governing body and facility operation	18	80.5	13.89	0.01	-0.420
Item 24: Organizational dynamics, political realities, and culture	18	77	15.41	0.11	-0.265
Item 25: Build trust and cooperation between/among stakeholders	18	84.5	15.46	0.04	-0.345
Item 26: Role and function of technology in operation	18	97	15.62	0.00	-0.475
Item 27: Confidentiality principles and laws	18	34	7.06	0.02	-0.378
Item 28: Corporate compliance laws and regulations	18	62	10.91	0.01	-0.443
Item 29: Patient rights, laws, and regulations	18	57	10.77	0.03	-0.372
Item 30: Risk mitigation	18	52.5	10.75	0.07	-0.302

Overall, trainees improved in competency and comfort based on pre- and post-test training measure across most items. Statistical analysis indicates, however, no improvement in competency was found across pre- and post-test training measure items 2, 4, 6, 15, 18, 21, and 24.

Improvement Scores

A descriptive statistical analysis was completed to determine areas for program improvement. Overall, the total improvement score median was 44.3 out of 50 points (*SD* = 3.95). The lowest rated improvement questions included "The training material was easy to understand and helpful," "The vocabulary used in the training was clear and easy to understand," "The training covered the material I expected," "The times scheduled for the agenda items were appropriate, and "This course met the objectives and my training needs" (See Table 3).

Table 3

Descriptive Statistical Analysis of Program Improvement

Item	Median	Std Dev
Item 1	4.5	.51
Item 2	4.5	.78
Item 3	4.5	.62
Item 4	4	.61
Item 5	5	.50
Item 6	4	.61
Item 7	5	.46
Item 8	4	.90
Item 9	4	.51
Item 10	4	.69

Chapter 4

Discussion

Though integrated behavioral health has been implemented in a variety of settings, effective treatment in some settings, such as a rural, general hospital ED, have not been explored. This may be due, in part, to systematic goals to quickly and efficiently assess, treat, and discharge a patient with a follow-up appointment or resources. While many general hospital EDs have systems in place to screen and refer presenting suicidal patients, these individuals are often the only ED patients who do not receive treatment before discharge or transfer to a psychiatric facility.

In line with the EPIS logic model, an intervention program and protocol was developed, which involved exploration of easily accessible interventions using ACT, including expectations and reinforcers for intervention participation. The preparation phase involved meetings with stakeholders, development of a training curriculum for multiple disciplines/groups (i.e*.,* undergraduate COs, crisis consultants, and medical staff), creation of protocols for intervention, and developing program evaluation measures for different components and stakeholders of the program.

The scope of this study was to complete the exploration and preparation phases of this program evaluation. Statistical analysis was completed on outcomes of staff trainings on the intervention protocol. Findings indicated that the training provided was effective in increasing their competency and comfort in administering the ACT-based interventions. Similarly,

participants felt the training was adequate and provided the necessary knowledge to complete their job, although it was noted that many were not expecting some of the material covered.

Summary

Across measures in training competency for undergraduate COs, overall significant improvement was achieved. Globally, COs felt the training of the intervention protocol was adequate and appropriately prepared them for the job they are to accomplish. However, some discrepancies were noted when individual item analysis was completed. Discussion of these summative findings follows.

No Significant Improvement

Findings suggest that of the competency domains assessed, COs felt less prepared in areas of relationship dynamics, appropriate social behavior and expectations for the setting, and communication regarding diversity. While the CO training did cover topics such as “key players” within the ED (i.e., doctors, nurses, BHCCs), little time was spent discussing the relational dynamics between them. For example, many hospital systems have a hierarchical model in decision making. While nurses were indicated as the decision makers and directors for the COs of when to begin the intervention protocol, medical doctors out-rank nurses within this system. In some instances, these challenging power dynamics may play out and if a doctor and nurse disagree, it may be difficult for the COs to know whose orders to follow. Future trainings should focus on discussing these possible dynamics and how the CO can navigate these possibly tension-filled encounters.

Additionally, regarding appropriate social behavior and expectations, these domains of training are thought to be a key aspect of the initial training COs undertake for hospital orientation, separate from the intervention protocol training. Future trainings may focus on how

to appropriately address the different stakeholders in a professional way. Likewise, given the COs are undergraduate students, this position may be their first professional job and they may feel less adequate on how to appropriately behavior in a professional setting. While this competency is often built over time as individuals learn how to navigate different professional settings, future trainings should incorporate discussions of appropriate behavior and expectations within a medical and ED setting. Providing examples, such as mock video interactions, may prove beneficial. This area in general may also be improved with clearer communication between the parties involved in hospital orientation training and the CO intervention protocol training. This would aid in detecting areas of competence that are not covered in one training and can be covered in the next.

CO training outcome measures also indicated they felt less prepared in the area of communication regarding diversity. The current training protocol spends time discussing diversity regarding mental health. That is, training included the differentiation between suicidal patients and homicidal patients and psychotic patients. While mental health professionals often understand that mental health in and of itself can bring a diverse array of experiences and presentations, this may be difficult for undergraduate students to adequately understand given their novel understanding of mental health. Additionally, it is hypothesized that the item in the outcome measure which mentions “diversity” does not provide context to what area of diversity is being evaluated and, most often, when discussing diversity, people may think of other diverse factors, such as ethnicity and race. As such, future trainings would benefit from differentiating the area of diversity being assessed, as well as incorporating additional training in other diversity markers. It is important for COs to understand that each individual’s diversity markers, such as race, ethnicity, sexual orientation, socioeconomic status, and more, bring with them a variety of

presentations when it comes to mental health. As such, incorporating more diversity training would benefit the COs as they work with culturally different people in the ED.

Interestingly, while COs indicated improvement in "Professional standards and codes of ethical behavior," they felt less competent to "Adhere to legal and regulatory standards." The difference in competence between these two items in the outcome measure is puzzling given the similarity in topic. However, looking over the training material covered, and the nuanced language used in the training outcome measures, it is likely the COs interpreted each item differently. CO training emphasized the importance of confidentiality and to not share information about patients outside of the hospital setting. It is hypothesized that while the trainees knew the ethical code of confidentiality in a general sense, they may have not realized the extent to which this applies and what consequences may follow after disclosing patient health information. Future iterations of the outcome measures may benefit from rewording certain items for clearer understanding, as well as placing additional emphasis on ethical standards in the training curriculum.

Significant Improvement

Of the domains assessed in the outcome measures, COs demonstrated significant improvement in multiple areas. This includes communication and relationship management, or the ability to communicate clearly and concisely with other professionals, as well as the ability to establish and maintain these relationships. Another area of growth surrounds leadership skills and behavior, or the COs ability to work collaboratively with an interdisciplinary team and successfully managing systemic changes that meet the goals of the organization. Likewise, COs also showed improvement in professionalism, demonstrating the ability to appropriately align personal and organizational ethical standards, as well as professional. The comfort in the area

also indicates the COs understood the responsibility they play in patient care and are service orientated.

Significant differences in pre- and post-training measures also indicated the COs were able to grow in knowledge of healthcare systems and organizations, as well as knowledge of healthcare personnel. These areas of growth, which fall under the topic of business skills and knowledge, also highlights the COs growth in knowledge of the patient's perspective, the organizational dynamics and governance of the system they are working, and risk management.

CO training incorporated a wide range of topics in order to build competence in administering the intervention protocol. Covering topics such as the continuum of suicidality, homicidality, and psychosis provided the trainees with ample perspective of the patient. This is an important topic to discuss as it provides the COs a look into those experiencing significant distress due to mental health. The COs likely felt a growth in competency in this area as this topic is often not covered in-depth until graduate psychology training. Likewise, the COs also participated in several trainings outside of the intervention protocol training, including a presentation specifically on suicidality, which likely added to the COs understanding of the patients' perspective and risk management.

Training discussions also focused on obstacles faced within a healthcare system, as well as basic ethics (i.e., confidentiality) and the different roles of the key stakeholders in the ED. These topics covered in the training likely addressed the competency domains of communication and relationship management, professionalism, knowledge of healthcare systems, organizations, and healthcare personnel, as well as organizational dynamics and governance. Additionally, given the training's focus on the intervention protocol and the COs' role in administering the intervention likely contributed to their competence and comfort in leadership skills and behavior.

Given this role is likely a first-time professional job for many of the COs, discussions regarding their role in the system and pivotal contribution to the safety of the patients likely attributed to their confidence and leadership capabilities.

Large Effect Size

Statistical analysis indicated this study produced a large effect size. Large effect sizes often indicate a greater magnitude of an effect or strength of a relationship. Having a large effect provides several indications. First, a large effect size in this study indicates the training was more than adequate at boosting the COs competency and comfort in administering the intervention protocol. Essentially, this was the main task of this study: to train new professionals in administering a much-needed intervention protocol to patients with little to no treatment while waiting for psychiatric placement or discharge. Second, a large effect size is useful for future studies as it provides a quantitative comparison to results of studies completed in different settings, as well as possible meta-analysis. This is an important finding to consider, as a goal of this training was to make it applicable for different settings needing similar intervention. This is highly beneficial as stakeholders indicated this intervention protocol would be useful in other Providence hospital systems in the area and potentially in other settings.

Improvement Item Outcomes

Overall, CO trainees indicated the structure and purpose of the training was adequate at meeting their needs for their jobs. While this is an optimal outcome overall, areas of improvement which were rated lower at meeting CO needs should be explored for future training improvement. Amongst post-training program improvement questions, the lowest rated included *The training material was easy to understand and helpful*, *The vocabulary used in the training was clear and easy to understand*, *The training covered the material I expected*, *The times scheduled for the*

agenda items were appropriate, and *This course met the objectives and my training needs*.

First, CO trainees indicated that some of the material used for training was not easy to understand or did not prove useful for their job descriptions. This is most likely due to the additional topics covered in the training curriculum, such as suicide risk assessment and the suicidality continuum. While this is important for COs to understand in order to effectively meet the needs of their patients and the hospital system in general, they do not complete any form of risk assessment while on duty. This is the job of the BHCC team and medical staff.

Additionally, as with any professional setting, particular language or vernacular is used throughout the training, such as “SI,” “HI,” “ACT,” and “contingency.” While these are common terms for graduate level psychology students and medical staff to use in daily interactions, undergraduate students who have not had exposure to more healthcare settings may find these words unfamiliar and difficult to follow. Future training may benefit from abstaining from the use of acronyms and utilize more easily understood terms to aid in the learning process.

COs also indicated possible improvement in the area of expectations, time management, and objectives. Future trainings may benefit from clearer expectations and objectives outlined prior to the start of the initial training process. This would provide COs with insight on what to be prepared to learn during the training while also providing clear indications as to why some of the material covered in the training is important for their jobs. Additionally, a clear timeline may prove beneficial in future trainings and would aid in optimal time management of the training.

Implications

In sum, results of the training outcome measures indicate the training was adequate at not only improving competence in CO job duties, but also their comfort in working in a high-stress and demanding healthcare setting. CO outcome measures indicated competence in areas such as

communication and relationship management, leadership skills and behavior, professionalism (i.e., personal and professional accountability), knowledge of healthcare systems and organizations, knowledge of healthcare personnel, knowledge of the patient's perspective, organizational dynamics and governance, and risk management. These are all key aspects of the COs job description and the duties they are to fulfill for the system. Additionally, results also indicate that not only were there significant differences in and pre- and post- test scores amongst CO trainees, but the overall effect of the training was greater than expected. This indicates the training could potentially be used in different Providence healthcare systems in the area, which was a hope of the stakeholders.

Limitations

While the current study found significant results overall, several limitations are noted. First, this study had a small sample size. While effect scores would indicate this study could be generalizable to other healthcare systems, a larger sample size with a similar effect size would greatly indicate the effectiveness of the training and its generalizability. Second, the current study utilized an EPIS logic model as a guide for program development and evaluation. While this model has been proven to be effective in different settings, particularly in healthcare settings, other logic models do exist and may possibly be more effective. Due to the fact that there were virtually no other studies with similar objectives, the comparison between this program evaluation logic model and another could not be completed. Additionally, the current study focused on only the first two stages of the EPIS model (i.e., Exploration and Preparation). Due to the current restrictions in place following the COVID-19 pandemic, the final two stages of the model could not be assessed. These are crucial steps as the Implementation and Sustainment stages provide crucial information on how effective the intervention protocol is at satisfying the

needs of the hospital system. Due to the pandemic, other measures which were created for this study were not utilized, which includes the satisfaction measure of the ED staff.

Future Research

Many areas for future research should be considered following this project. First, given that the program could not be fully implemented to the patients awaiting psychiatric hospitalization due to COVID-19 restrictions, it is important to continue this process following the resolution of the current pandemic. Alongside this, this study's aim was not to analyze the effectiveness of the actual interventions administered to the patients. This would be a crucial next step in the program development process, which could later adjust or recreate the interventions provided and optimize the sustainment of the protocol.

Regarding training competencies, future trainings may incorporate the totality of The American College of Healthcare Executives (ACHE) Healthcare Executive Competencies Assessment Tools (Garman & Tran, 2006). An updated, 2020 version of this tool was released following the completion of this study. Future studies may find the updated version useful in assessing for CO competencies and that utilizing the entire assessment tool would prove beneficial at assessing overall competency in healthcare management.

Additionally, this project utilized technology (i.e., iPads and Apple TVs) which many community hospitals may not have access to. It is important to develop alternatives to how these interventions are administered. Likewise, these alternatives should also take into consideration the health and safety of both the patients and those who provide the interventions.

Lastly, the materials used for the intervention protocol were created using only the English language. When in a rural environment, language is often a barrier to the care one receives. As such, future studies should incorporate protocols for those who speak a language

other than English, such as Spanish.

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Appendix A

Training Curriculum PowerPoint

Behavioral Health Crisis Constant Observer Training

George Fox University

Providence Newberg Medical Center

2019

associated research through George Fox University. We are interested in exploring the effectiveness of the training curriculum related to the Behavioral Health Constant Observer program and the inclusion of interventions for individuals in crisis while awaiting psychiatric hospitalization.

INFORMATION

Involvement
Through participation in the Behavioral Health Crisis Intervention training program, you will be asked to complete a pre- and post-survey related to the training of the program. Data collected from the surveys will be used to increase the effectiveness of the training for future use.

Foreseeable risks or discomfort
Participation in this study involves no extra time commitment than that involved in the Constant Observer training process. Efforts will be made to protect identifying information, and the confidentiality of research participants.

Benefits
There is no financial compensation for participation in this study. However, the training and participation in this program are of educational benefit and opportunity.

Confidentiality
Confidentiality of personal information and data collected will be protected through use of participant ID numbers on forms collected, and with a separate secure file that contains the links between subject names and ID numbers. All electronic data will be password protected. Physical data (test protocols, forms) will be stored in a locked filing cabinet in a locked office.

Voluntary Involvement
Your agreement to allow this data that is being collected to be used for research purposes is voluntary. Refusal to participate will involve no penalty or loss of program benefits to which the crewmember is otherwise entitled. You may also discontinue participation at any time up until data analyses are completed.

AGREEMENT
I, the undersigned, agree to participate in intervention training for Behavioral Health Crisis Intervention in the Emergency Department of Providence Newberg Medical Center. I also agree to complete a series of pre- and post-questionnaires related to the Constant Observer training program.

I understand that this information is being gathered for research purposes, and that the person gathering the

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

Age:

- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 and older

Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Gender not listed:_______________

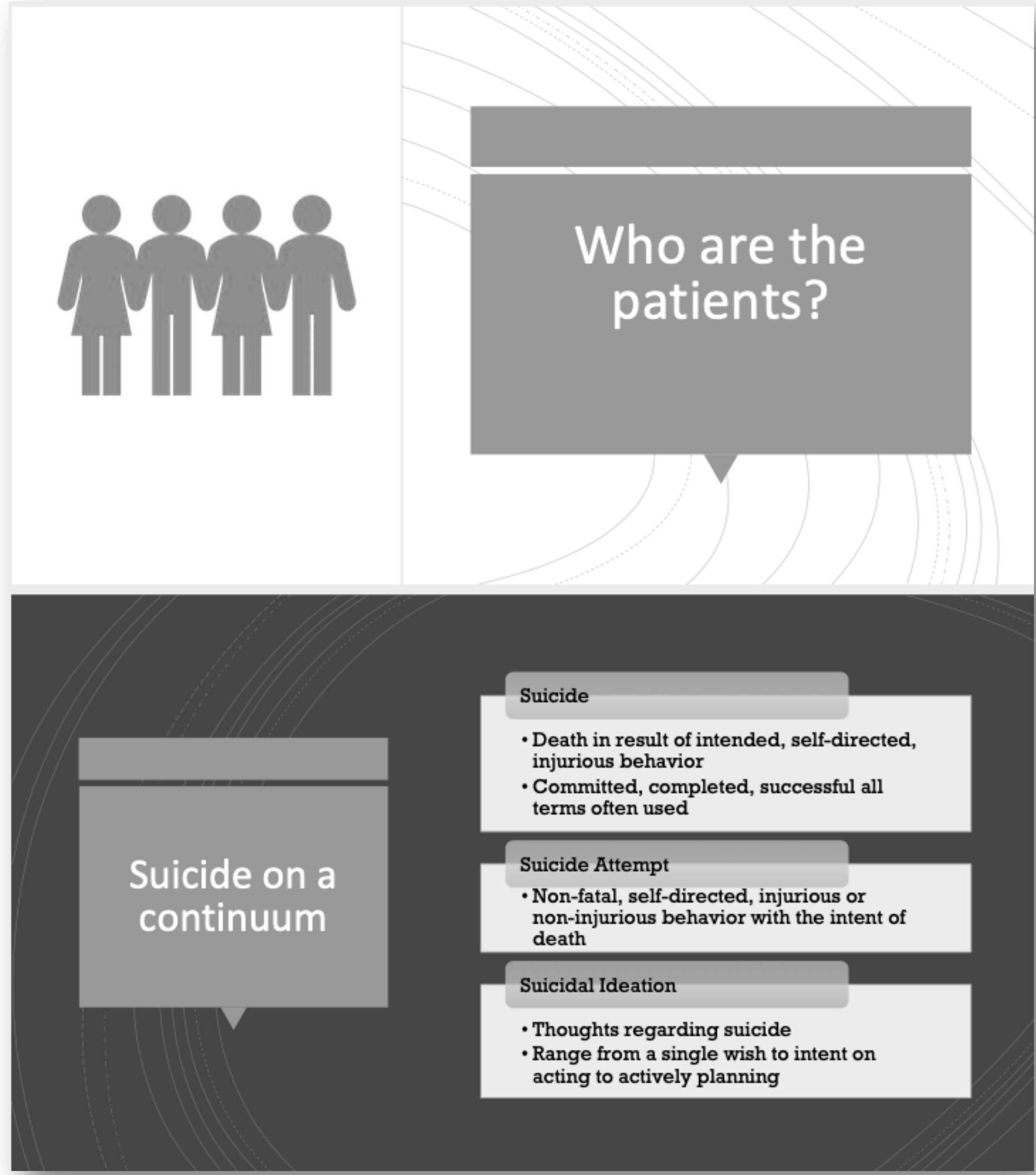
Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latino/Latina/Latinx, or Spanish Origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or European American
- ☐ Another race/ethnicity not listed:_______________

PRE-TRAINING SURVEY

How competent, or capable, do you feel in these different areas related to your job as a Constant Observer in the Emergency Department?
**Please circle the best answer and be honest.

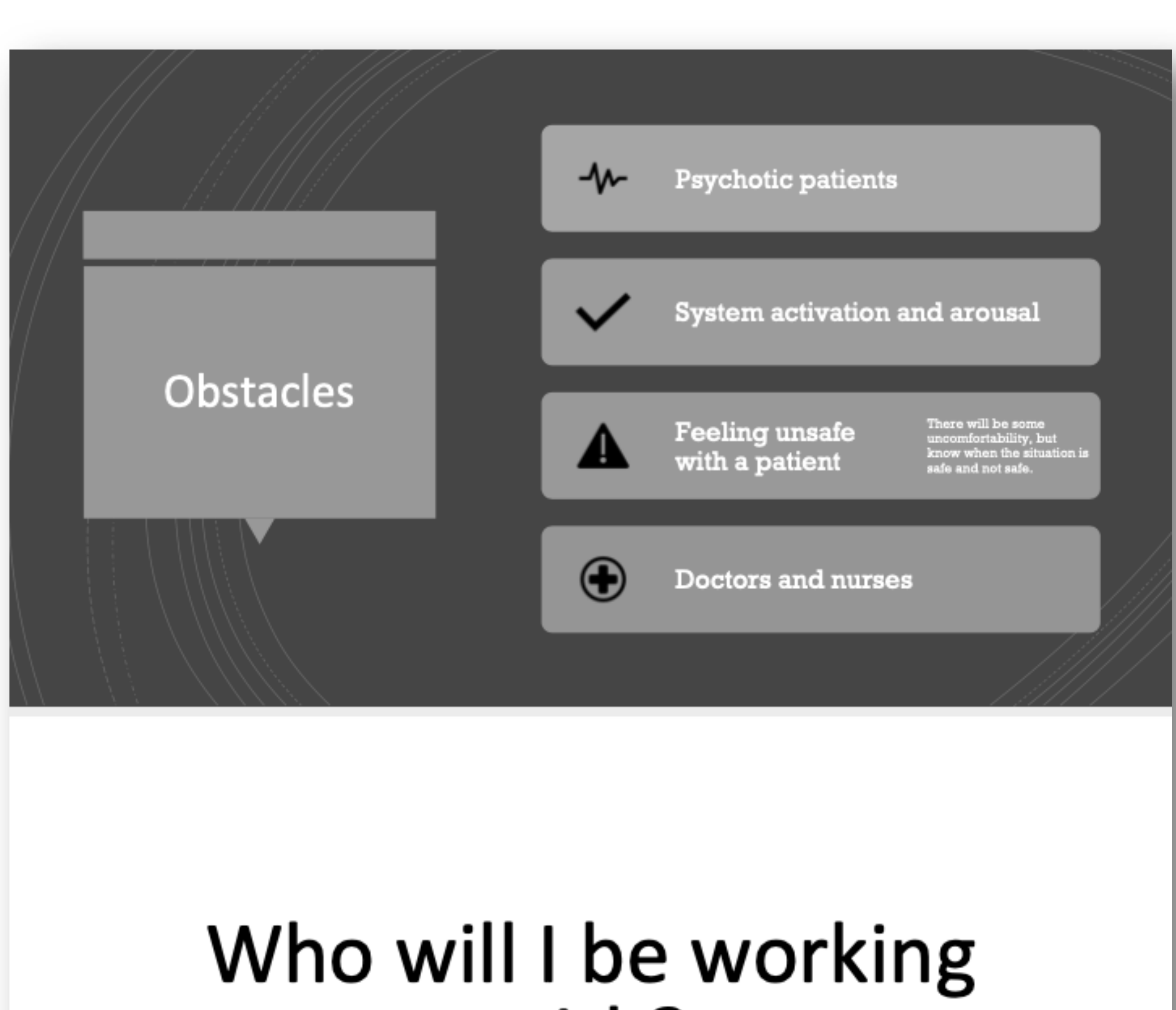
1. Organizational structure and relationships.
   1 2 3 4 5
2. Demonstrate effective interpersonal relations.
   1 2 3 4 5
3. Identify stakeholder needs/expectations.
   1 2 3 4 5
4. Sensitivity to what is appropriate behavior when communicating with diverse cultures, both internal and external.
   1 2 3 4 5
5. Receive constructive feedback.
   1 2 3 4 5
6. Adhere to legal and regulatory standards.
   1 2 3 4 5


Who are the patients?
Suicide on a continuum
Suicide
• Death in result of intended, self-directed, injurious behavior
• Committed, completed, successful all terms often used
Suicide Attempt
• Non-fatal, self-directed, injurious or non-injurious behavior with the intent of death
Suicidal Ideation
• Thoughts regarding suicide
• Range from a single wish to intent on acting to actively planning

Homicide on a continuum
Homicide
Death in result of intended, directed, injurious behavior
Committed, completed, successful all terms often used
Homicide Attempt
Non-fatal, directed, injurious or non-injurious behavior with the intent of death
Homicidal Ideation
Thoughts regarding homicide
Range from a single wish to intent on acting to actively planning
Psychosis
Losing touch with reality
To see, hear, or believe things that are not real
Delusions
Held belief of untrue or strange beliefs
Hallucinations
Hearing or seeing something that is not there
Psychosis is not an illness, it is a symptom
Mental or physical illness, substance abuse, or extreme stress/trauma

Ethics
Confidentiality
• Maintaining: "primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship"
• Disclosure: "may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law"
HIPPA

CONFIDENTIAL
In sum:
Don't tell you friends, girlfriend/boyfriend/partner, family, etc.
Keep it to yourself unless it is a professional working on the patient's care.


Obstacles
Psychotic patients
System activation and arousal
Feeling unsafe with a patient
There will be some uncomfortability, but know when the situation is safe and not safe.
Doctors and nurses
Who will I be working with?

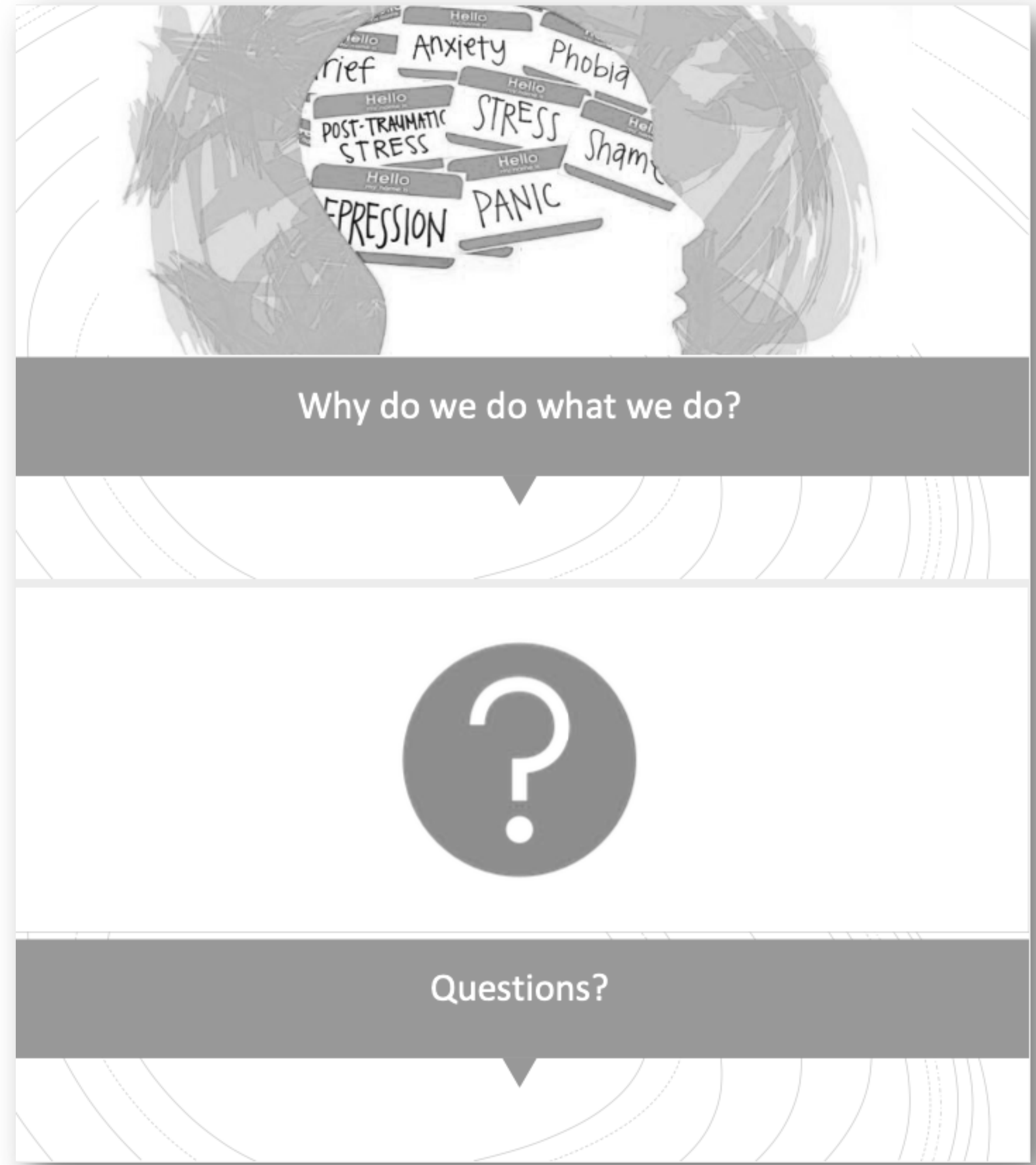
Learn the Roles: BHCC

- Providing behavioral health consultation to local Emergency Departments regarding suicidal/homicidal risk during night and weekends
- BHCC will decide if patients are stable enough to participate
  - Nurses will do the same

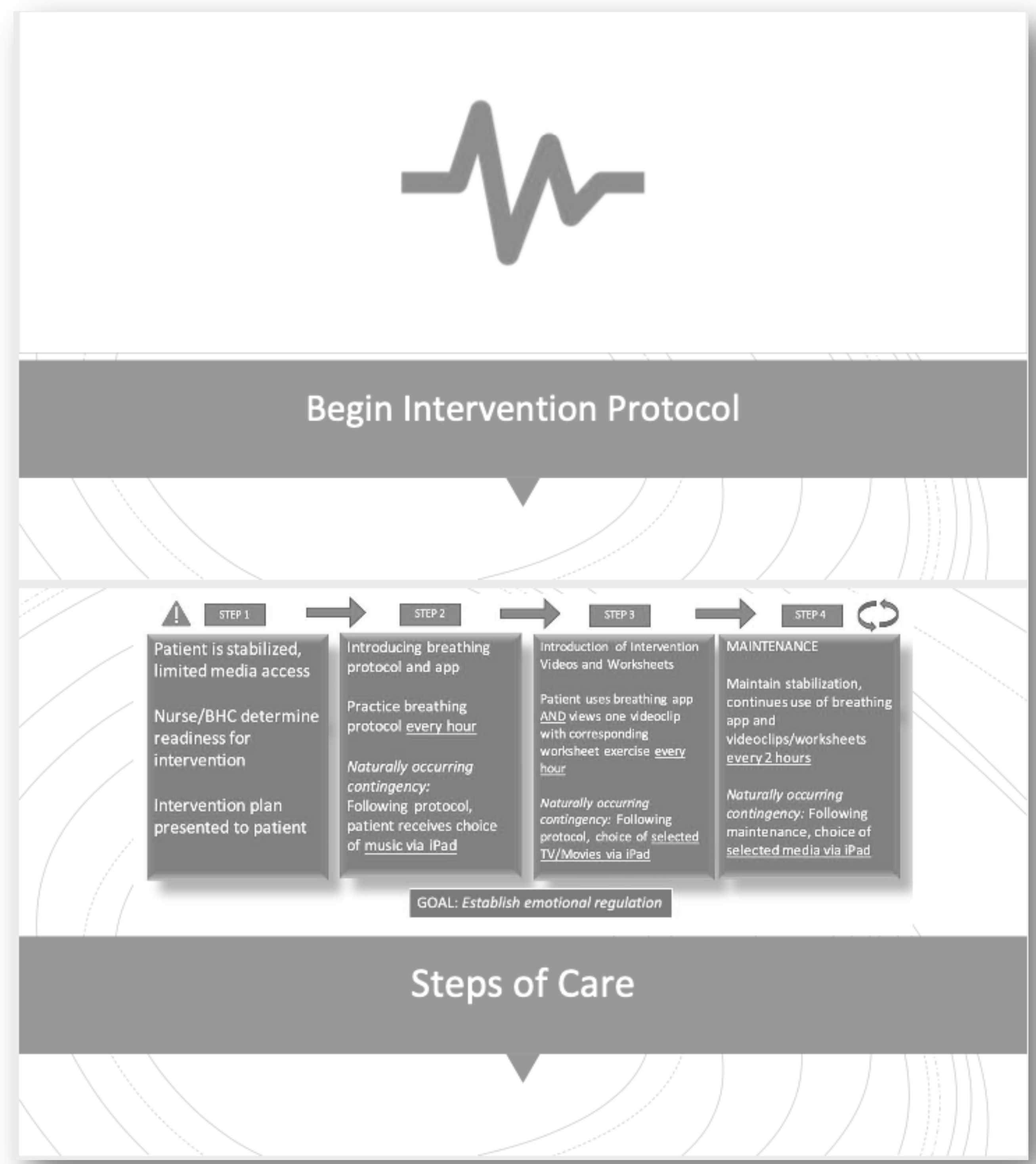
Working in a healthcare setting

The Food Chain
- Attending physician
- Nurses
- Behavioral Health Crisis Consultant/County Mental Health Provider
- Constant Observer

What you will see/hear in the Emergency Department
- Emergencies
- Mental Health
- Screaming/yelling
- Tears
- Death
- High arousal


Anxiety
Phobia
POST-TRAUMATIC STRESS
STRESS
PANIC
Why do we do what we do?
Questions?

Intervention Protocol 101
Patient is triaged
Behavioral Health Crisis Assessment completed
Provider orders Constant Observer
GOAL: Establish emotional regulation
Before you even go in…


Begin Intervention Protocol
STEP 1
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Nurse/BHC determine readiness for intervention
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STEP 2
Introducing breathing protocol and app
Practice breathing protocol every hour
Naturally occurring contingency: Following protocol, patient receives choice of music via iPad
STEP 3
Introduction of Intervention Videos and Worksheets
Patient uses breathing app AND views one videoclip with corresponding worksheet exercise every hour
Naturally occurring contingency: Following protocol, choice of selected TV/Movies via iPad
STEP 4
MAINTENANCE
Maintain stabilization, continues use of breathing app and videoclips/worksheets every 2 hours
Naturally occurring contingency: Following maintenance, choice of selected media via iPad
GOAL: Establish emotional regulation
Steps of Care

Constant Observer Protocol

i. Patient is triaged
ii. Behavioral Health Crisis Assessment Completed
   a. Hospitalization is determined
iii. Provider order *Constant Observer*

1. Step 1
   a. Patient is stabilized with limited media access
   b. Nurse/BHC determine readiness for intervention
   c. **Intervention plan is presented to the patient**
2. Step 2
   a. Introduce breathing protocol and app
      i. **TURN ON SCREEEN MIRRORING**
   b. **Open PATIENT DIRECTIONS—A** and allow time for patient to read and comprehend instructions
   c. **Open CALM app**
      i. **In bottom, right-hand corner click MORE**
      ii. **Tap BREATHE**
      iii. **Set duration to 5 MINUTES and click START BREATHING**
         1. Watch patient on monitor to determine if they are engaging with the breathing exercise
      iv. **RECORD PATIENT ENGAGEMENT** ("Engaged" or "Not Engaged")
      v. **REPEAT EVERY HOUR**
   d. **ALLOW PATIENT TO SELECT MUSIC TO LISTEN TO IN-BETWEEN EXERCISES**
3. Step 3 (*Begin once patient demonstrates ability to engage in breathing (minimum of 3 times)
   a. Introduce intervention videos and worksheets
      i. **TURN ON SCREEN MIRRORING**
   b. **FOLLOW STEP 2 with breathing time at 2 MINUTES**
      i. Priming patient before transitioning to Step 3
   c. **Open PATIENT DIRECTIONS—B** and allow time for patient to read and comprehend instructions
   d. **Open INTERVENTION VIDEOS document in FILES**
   e. **Click ONE VIDEO and allow video to load and play (make full screen)**
   f. **Following, provide patient with WORKSHEET associated with video watched**
   g. **REPEAT EVERY 1 HOUR** until patient demonstrates full engagement
   h. **AFTER TWO CONSECUTIVE COMPLETIONS OF VIDEO/WORKSHEET EXERCISES, ALLOW PATIENT TO PICK SELECTTED MEDIA.**
4. Step 4
   a. Maintain stabilization, continuing breathing app and video clips w/worksheets
   b. **Once patient demonstrates ability to engage in material, REPEAT STEP 3 EVERY 2 HOURS**

AirPlay video from your iPhone, iPad, or iPod touch

1. Connect your iOS device to the same Wi-Fi network as your Apple TV or AirPlay 2-compatible smart TV.
2. Find the video that you want to AirPlay.
3. Tap . In some third-party apps, you might need to tap a different icon first.* In the Photos app, tap , then tap .
4. Choose your Apple TV or AirPlay 2-compatible smart TV. Need help?

To stop streaming, tap in the app that you're streaming from, then tap your iPhone, iPad, or iPod touch from the list.

*Some video apps on iOS might not support AirPlay. If you can't use AirPlay with a video app, check the App Store for tvOS to see if that app is available on Apple TV.

If video automatically streams to an AirPlay device

Your iOS device might automatically AirPlay video to the Apple TV or AirPlay 2-compatible smart TV that you frequently use. If you open a video app and see in the upper-left corner, then an AirPlay device is already selected.

To use AirPlay with a different device, tap , then tap another device, or tap "iPhone" to stop streaming with AirPlay.

We are about to show you a breathing exercise.

We hope you take this exercise out in your life and practice deep breathing when things are overwhelming or stress provoking.

The instructions are simple:
Breathe in.
Hold your breath.
Breathe out.
Repeat.

This exercise will last for 5 minutes.

You can follow the on-screen instructions.

Participation in this practice will grant you time to listen to music from your favorite artist.

Constant Observer Protocol

i. Patient is triaged
ii. Behavioral Health Crisis Assessment Completed
  a. Hospitalization is determined
iii. Provider order *Constant Observer*

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      i. **In bottom, right-hand corner click MORE**
      ii. **Tap BREATHE**
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   d. **Open INTERVENTION VIDEOS document in FILES**
   e. **Click ONE VIDEO and allow video to load and play (make full screen)**
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4. Step 4
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   b. **Once patient demonstrates ability to engage in material, <u>REPEAT STEP 3 EVERY 2 HOURS</u>**

We are about to show you a video.

We hope the videos will help explain what you are going through, how to deal with it, and how to take charge of your life again.

Following each video, we will provide you with a worksheet to help you think about how the concepts in the videos can apply to your life.

The instructions are simple:
Watch the video.
Fill out the provided worksheet.

Participating in this activity will allow you to choose a TV show or movie from our selection of media from Netflix.

CHOICE OF VIDEOS

Passengers on A Bus*

Why Mindfulness is a Superpower

The Unwelcome Party Guest*

Leaves on a Stream*

The Choice Point*

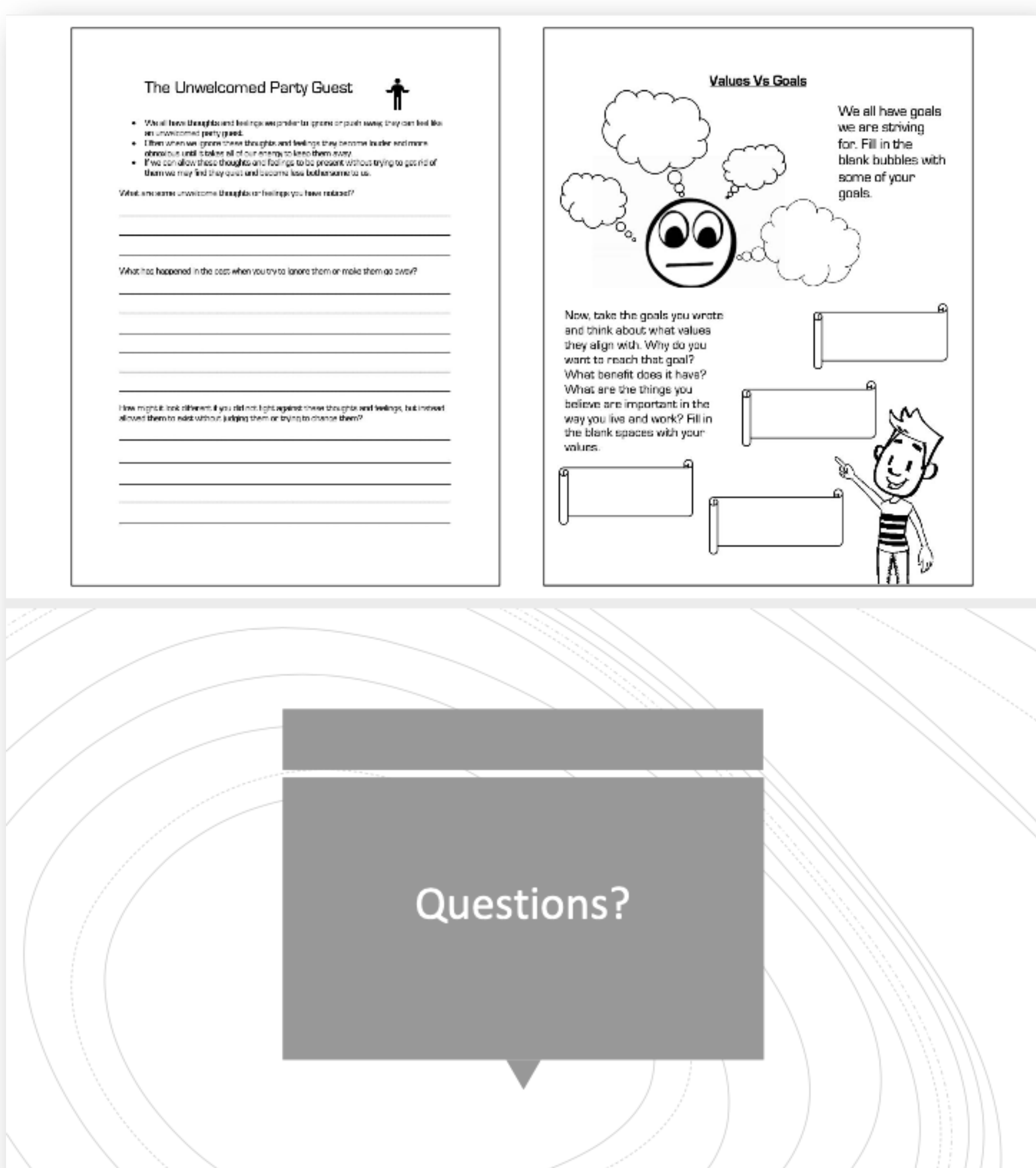
The Struggle Switch*

The 3 Happiness Myths

Values vs Goals

*= more appropriate for children and adolescents; use discretion

What it looks like…



The Unwelcomed Party Guest
Values Vs Goals
We all have goals we are striving for. Fill in the blank bubbles with some of your goals.
Now, take the goals you wrote and think about what values they align with. Why do you want to reach that goal? What benefit does it have? What are the things you believe are important in the way you live and work? Fill in the blank spaces with your values.
Questions?

Constant Observer Protocol

i. Patient is triaged
ii. Behavioral Health Crisis Assessment Completed
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iii. Provider order *Constant Observer*

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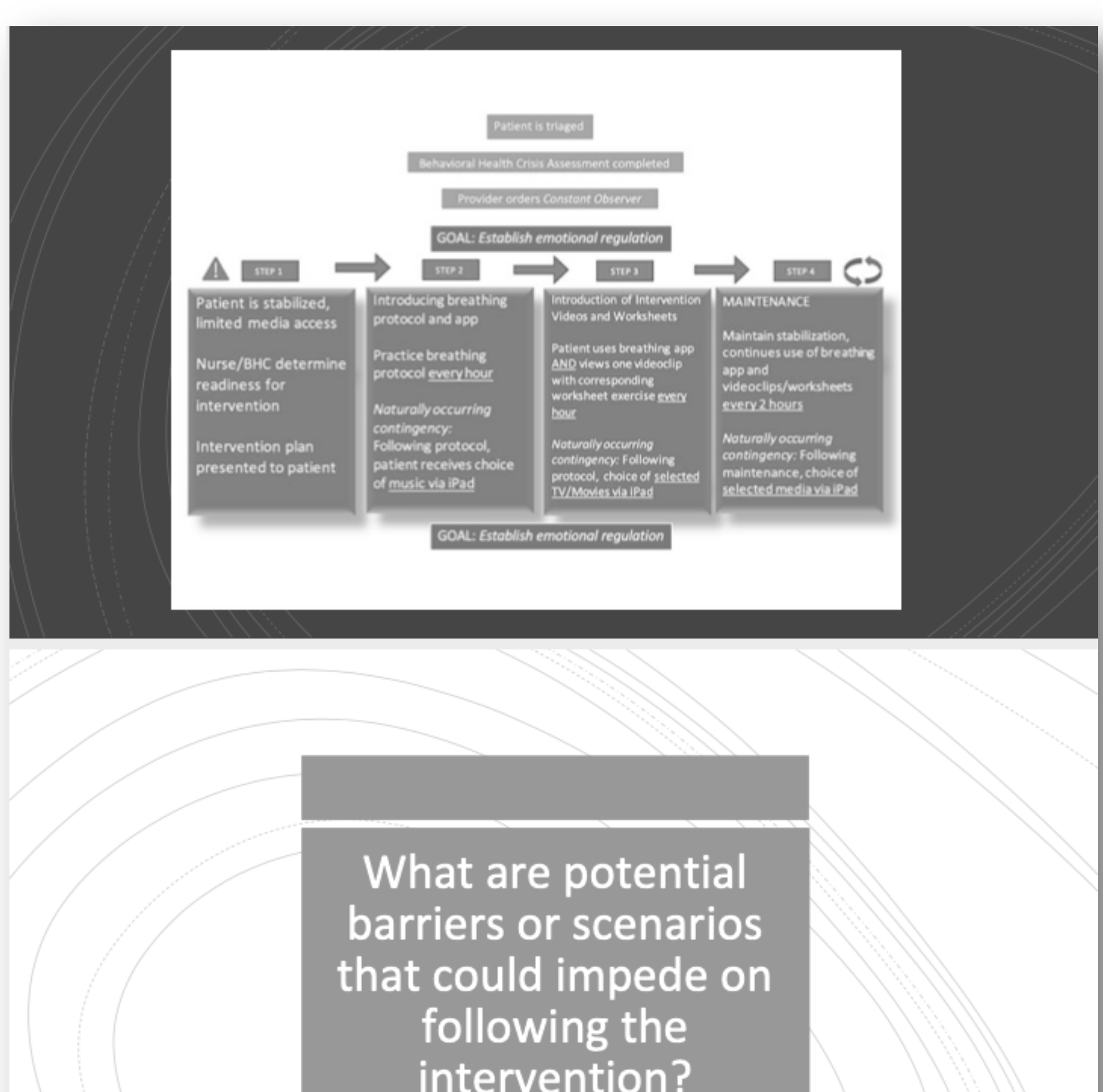
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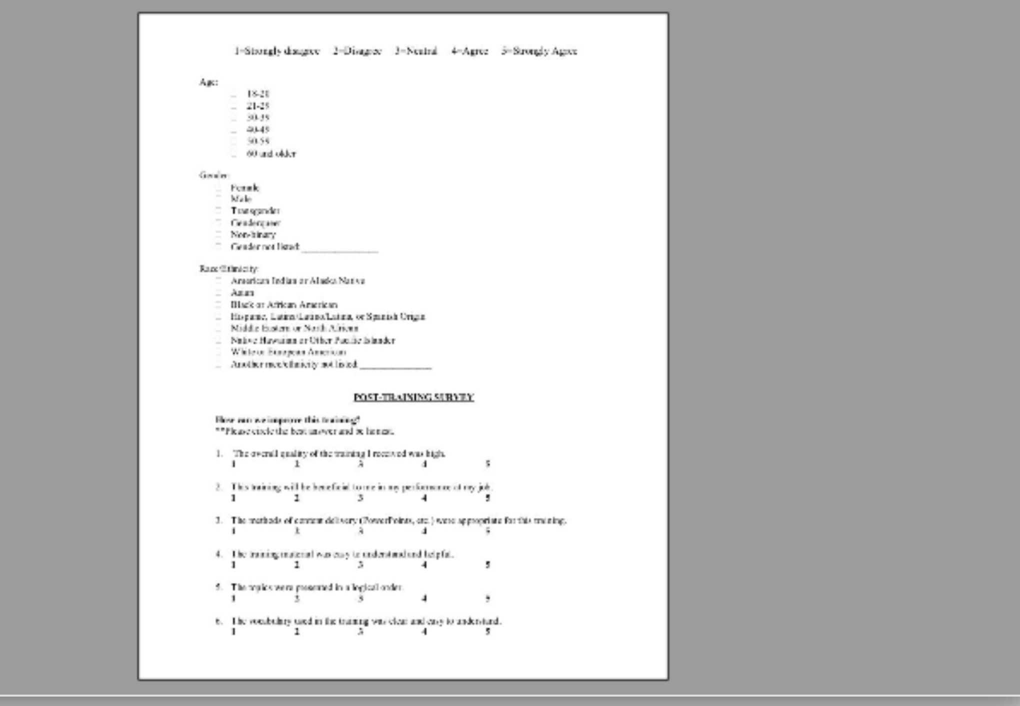
Naturally occurring contingency: Following maintenance, choice of selected media via iPad
GOAL: Establish emotional regulation
What are potential barriers or scenarios that could impede on following the intervention?

Let's Practice!



1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

Age:
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- 21-25
- 30-35
- 40-45
- 50-55
- 60 and older

Gender:
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- Male
- Transgender
- Genderqueer
- Non-binary
- Gender not listed: ______________

Race/Ethnicity:
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- Asian
- Black or African American
- Hispanic, Latino/Latina/Latinx, or Spanish Origin
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White or European American
- Another race/ethnicity not listed ______________

POST-TRAINING SURVEY

How can we improve this training?
**Please circle the best answer and be honest.

1. The overall quality of the training I received was high.
   1 2 3 4 5
2. This training will be beneficial to me in my performance of my job.
   1 2 3 4 5
3. The methods of content delivery (PowerPoints, etc.) were appropriate for this training.
   1 2 3 4 5
4. The training material was easy to understand and helpful.
   1 2 3 4 5
5. The topics were presented in a logical order.
   1 2 3 4 5
6. The vocabulary used in the training was clear and easy to understand.
   1 2 3 4 5

Final thoughts and questions

Appendix B

Constant Observer Protocol Material

Constant Observer Protocol

i. Patient is triaged
ii. Behavioral Health Crisis Assessment Completed
   a. Hospitalization is determined
iii. Provider order *Constant Observer*

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   e. **Click ONE VIDEO and allow video to load and play (make full screen)**
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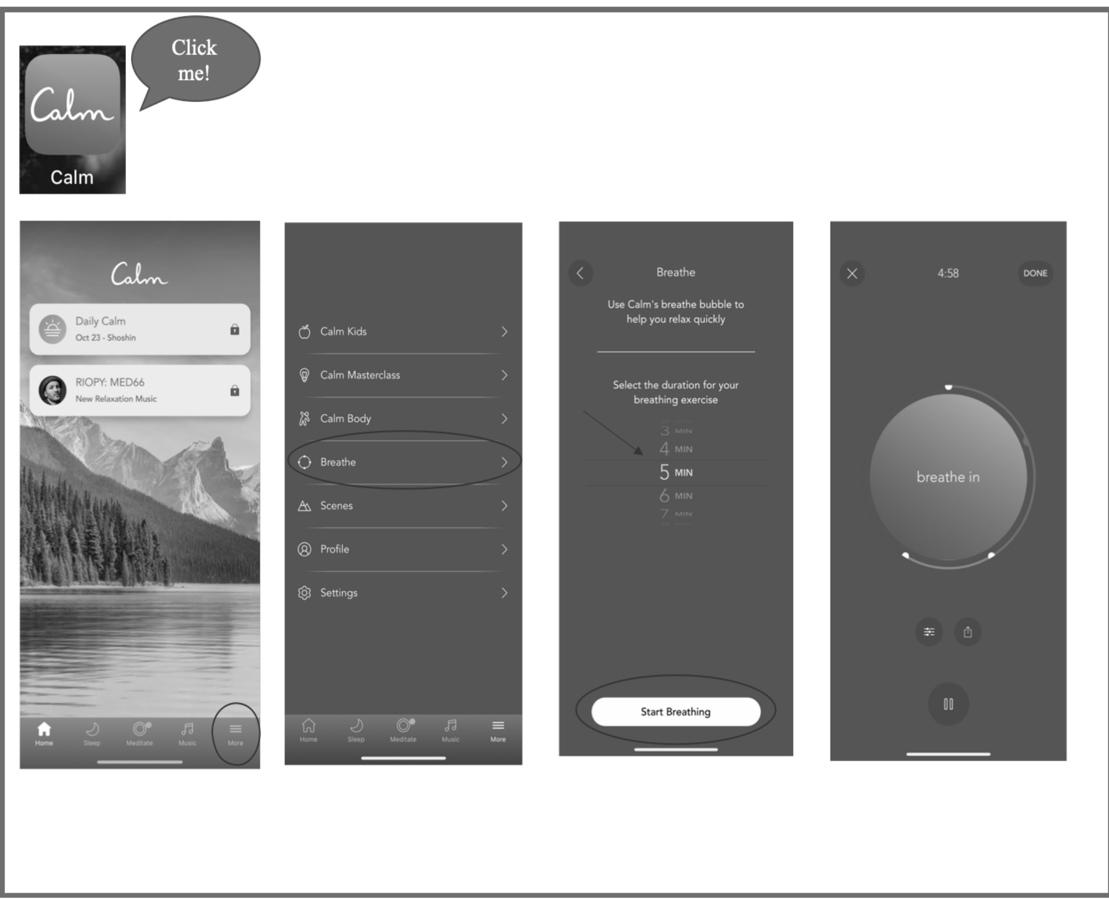

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Participating in this activity will allow you to choose a TV show or movie from our selection of media from Netflix.

Date:____________________

ED BEHAVIORAL HEALTH CONSTTANT OBSERVER INTERVENTION TRACKING FORM

Patient Intervention Engagement, Intervention Type, and Contingency Code Legend				
Patient appears to be:	**E** – Engaged in intervention	**NE** – Not engaged in intervention	**S** – Sleeping, unable to engage	**O** – Occupied (w/doc, nurse, family, friends, screener, etc), unable to engage
Patient engaged in:	**CB** – Calm breathing (Intervention 1)	**VW** – Videos/Worksheets (Intervention 2)	**M** – Maintenance Intervention (Interventions 1 & 2)	
Patient contingency choice:	**MC** – Choice of music	**NX** – Choice of visual media (Netflix, Youtube, etc)	**OR** – Other choice of media (please use discretion)	

	Engage:	Intervention:	Contin.		Engage:	Intervention:	Contin.		Engage:	Intervention:	Contin.
0000				0800				1600			
0015				0815				1615			
0030				0830				1630			
0045				0845				1645			
0100				0900				1700			
0115				0915				1715			
0130				0930				1730			
0145				0945				1745			
0200				1000				1800			
0215				1015				1815			
0230				1030				1830			
0245				1045				1845			
0300				1100				1900			
0315				1115				1915			
0330				1130				1930			
0345				1145				1945			
0400				1200				2000			
0415				1215				2015			
0430				1230				2030			
0445				1245				2045			
0500				1300				2100			
0515				1315				2115			
0530				1330				2130			
0545				1345				2145			
0600				1400				2200			
0615				1415				2215			
0630				1430				2230			
0645				1445				2245			
0700				1500				2300			
0715				1515				2315			
0730				1530				2330			
0745				1545				2345			

IPAD LOG IN INFO

Username: ProvidenceCOIntervention@gmail.com

Password: GeorgeFox123

PATIENT ID

GEORGE FOX UNIVERSITY

Graduate School of Clinical Psychology

416 N. Meridian St. V104 | Newberg, OR 97132 | georgefox.edu

Appendix C

Acceptance and Commitment Intervention Material

CHOICE OF VIDEOS

Passengers on A Bus*

Why Mindfulness is a Superpower

The Unwelcome Party Guest*

Leaves on a Stream*

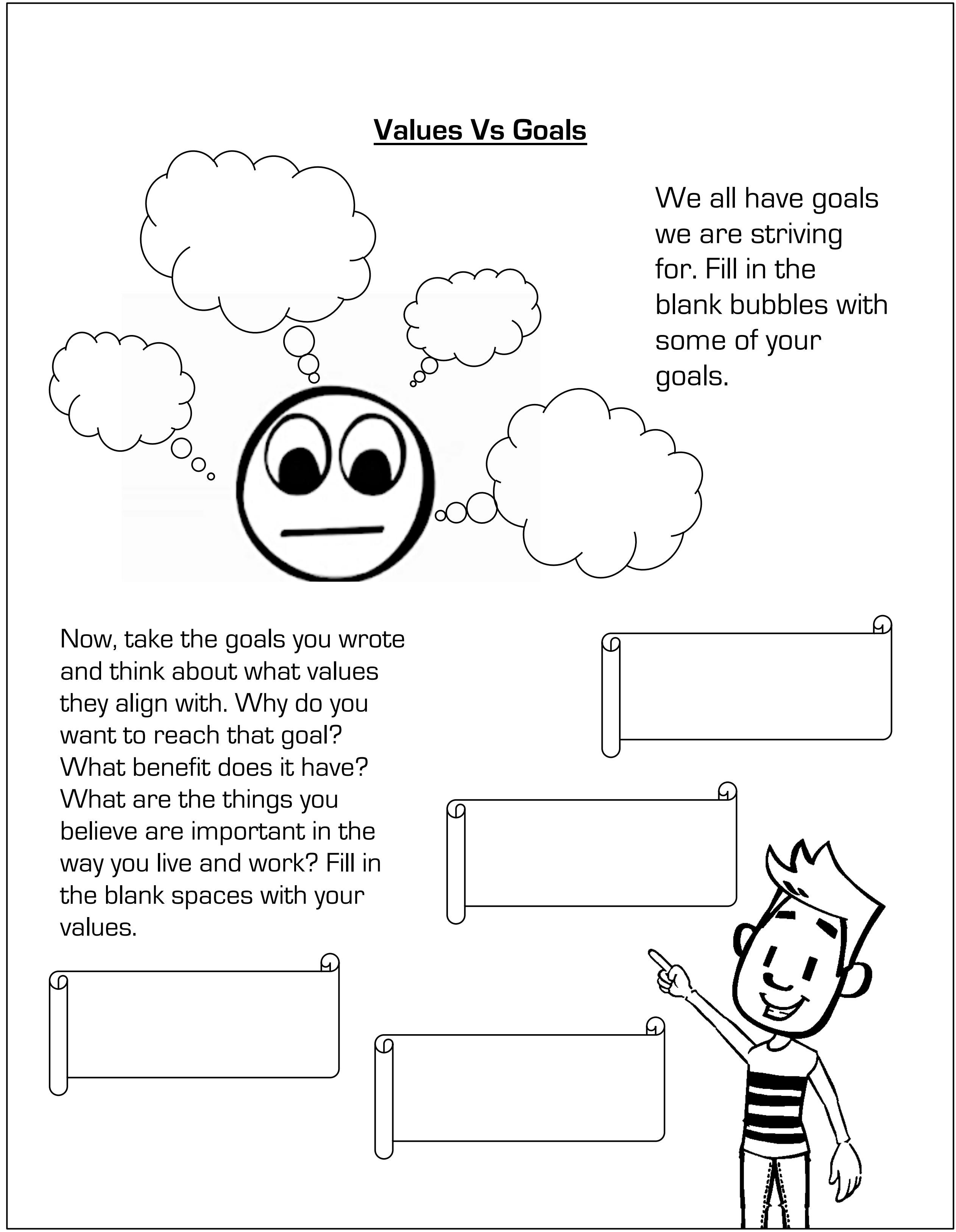
The Choice Point*

The Struggle Switch*

The 3 Happiness Myths

Values vs Goals

*= more appropriate for children and adolescents; use discretion


Values Vs Goals
We all have goals we are striving for. Fill in the blank bubbles with some of your goals.
Now, take the goals you wrote and think about what values they align with. Why do you want to reach that goal? What benefit does it have? What are the things you believe are important in the way you live and work? Fill in the blank spaces with your values.

The Unwelcomed Party Guest

- We all have thoughts and feelings we prefer to ignore or push away; they can feel like an unwelcomed party guest.
- Often when we ignore these thoughts and feelings they become louder and more obnoxious until it takes all of our energy to keep them away.
- If we can allow these thoughts and feelings to be present without trying to get rid of them we may find they quiet and become less bothersome to us.

What are some unwelcome thoughts or feelings you have noticed?

____

____

____

What has happened in the past when you try to ignore them or make them go away?

____

____

____

____

____

____

How might it look different if you did not fight against these thoughts and feelings, but instead allowed them to exist without judging them or trying to change them?

____

____

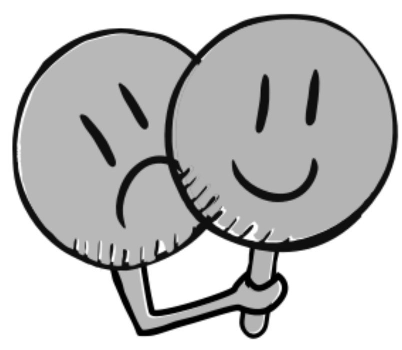
____

____

____

The 3 Happiness Myths

1. Happiness is the natural state for human beings
    a. *Realignment*: In reality, the natural state is an ever-changing flow of emotions. Sometimes we're happy, sometimes sad, sometimes angry. Each state brings a different dimension to our lives and broadens our overall experience.
2. Happiness means feeling good
    a. *Realignment*: Happiness is living a rich, full, and meaningful life. Meaning comes from stretching ourselves across the full range of our emotions, without running away from the less pleasant ones.
3. If we're not happy, we're defective: If we're not happy, then there's something wrong with us.
    a. *Realignment*: In reality, if you're not happy, you're normal. Life is difficult. Difficult experiences give us challenges for learn. So, embrace that difficulty, even enjoy it.



What are some emotions you have felt when you thought you should be happy?

____

____

____

____

____

- All of us have things and people we value
- The things we do every day can either move us towards these values or away from them.
- Often we get stuck at the choice point, or the moment we choose an action that will move us towards or away from our values.

Values: Who/What do you value most?

____

____

Away Moves: What do you notice yourself doing that moves you away from these values?

____

____

Towards Move: How do you moved towards these values?

____

____

Unhooking: We can sometimes get hooked or stuck on unhelpful thoughts or feelings that get in the way of moving towards our values.

Here are some ways you can unhook from unhelpful thoughts and feelings that might get in the way of moving towards your values, circle some that may work for you:

Thank your mind	Redirect your focus	Become and observer
Name your thought/feeling	Come back to now	Notice when you're judging

Struggle Switch

- Sometimes we feel like we have a struggle switch in our mind.
- When an unwanted thought or feeling shows up the struggle switch turns on and we find ourselves trying to get rid of or fight the thought/feeling.
- This can make our unwanted thought/feeling stronger and harder to manage.

What are some thoughts and feelings that you notice turn your brain's struggle switch ON?

____

____

____

____

What happens when you fight these thoughts/feelings? Are there other thoughts/feelings that come when you struggle with them?

____

____

____

____

How might things be different if you turned the struggle switch off and allowed these thoughts/feelings to simply be and did not fight them or try to change them?

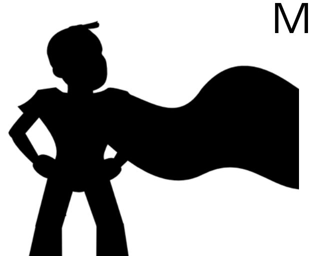
____

____

____

____

Mindfulness is a Superpower



Mindfulness is the ability to know what's happening in your head at any given moment without getting carried away by it.

- We all have thoughts, feelings, and reactions to things that happen in life every day.
- Often we jump into these with no space between the situation and our reaction.
- Mindfulness gives us the space to notice these reactions without being carried away by them.

How can we mindfully notice?
Think of a situation that upsets you or causes you stress: ______________________________

Thoughts:

____

____

____

Feelings:

____

____

____

Actions:

____

____

____

How might you react differently if you take time to notice these thoughts, feeling, and actions before jumping immediately to your reaction?

____

Leaves on a Stream

- Sometimes we have thoughts/feelings we get stuck on.
- When we try to hold onto these thoughts they can become harder to manage.

What are some thoughts/feelings you find yourself feeling stuck with a lot?

____

____

____

In what ways are these thoughts/feelings valid?

____

____

____

In what ways are these thoughts/feelings not helping you?

____

____

____

What would it feel like if you could place these thought/feelings on a leaf and watch them float away down a mountain stream?

____

____

____

NHS
Persistent Physical Symptoms Service

Worksheet 3.2
Passengers on the bus

Complete the diagram below with the details of your own bus. What value are you trying to head towards? Fill this in as the destination of the bus. What passengers get in your way? Write down the kinds of things they say to you in the speech bubble.

Physical Health and Rehabilitation Psychology Service – Cumbria Partnership NHS Foundation Trust

Appendix D

Pre-Training Measure

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

Age:
- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 and older

Gender:
- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Gender not listed:________________

Race/Ethnicity:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latinx/Latino/Latina, or Spanish Origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or European American
- ☐ Another race/ethnicity not listed:_______________

PRE-TRAINING SURVEY

How competent, or capable, do you feel in these different areas related to your job as a Constant Observer in the Emergency Department?
**Please circle the best answer and be honest.

1. Organizational structure and relationships.
   1 2 3 4 5

2. Demonstrate effective interpersonal relations.
   1 2 3 4 5

3. Identify stakeholder needs/expectations.
   1 2 3 4 5

4. Sensitivity to what is appropriate behavior when communicating with diverse cultures, both internal and external.
   1 2 3 4 5

5. Receive constructive feedback.
   1 2 3 4 5

6. Adhere to legal and regulatory standards.
   1 2 3 4 5

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

7. Foster an environment of mutual trust.
   1 2 3 4 5

8. Explore opportunities for the growth and development of the organization on a continuous basis.
   1 2 3 4 5

9. Anticipate and plan strategies for overcoming obstacles.
   1 2 3 4 5

10. Patient's rights and responsibilities.
    1 2 3 4 5

11. Consequences of unethical actions.
    1 2 3 4 5

12. Professional roles, responsibility, and accountability.
    1 2 3 4 5

13. Professional standards and codes of ethical behavior.
    1 2 3 4 5

14. Uphold and act upon ethical and professional standards.
    1 2 3 4 5

15. Adhere to ethical business principles.
    1 2 3 4 5

16. Healthcare and medical terminology.
    1 2 3 4 5

17. Physician, nurse, and BHCC roles.
    1 2 3 4 5

18. Constant Observer roles.
    1 2 3 4 5

19. The patient's perspective (e.g., cultural differences, expectations, psychopathology, etc.).
    1 2 3 4 5

20. Organization and delivery of healthcare.
    1 2 3 4 5

21. Standards of care.
    1 2 3 4 5

22. Evidence-based practice.
    1 2 3 4 5

23. Medical staff structure and its relationship to the governing body and facility operation.
    1 2 3 4 5

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

24. Organizational dynamics, political realities, and culture.
    1 2 3 4 5

25. Build trust and cooperation between/among stakeholders.
    1 2 3 4 5

26. Role and function of technology in operation.
    1 2 3 4 5

27. Confidentiality principles and laws.
    1 2 3 4 5

28. Corporate compliance laws and regulations.
    1 2 3 4 5

29. Patient rights, laws, and regulations.
    1 2 3 4 5

30. Risk mitigation.
    1 2 3 4 5

Appendix E

Post-Training Measure

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

Age:

- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 and older

Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Gender not listed:________________

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latinx/Latino/Latina, or Spanish Origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or European American
- ☐ Another race/ethnicity not listed:_______________

POST-TRAINING SURVEY

How can we improve this training?
**Please circle the best answer and be honest.

1. The overall quality of the training I received was high.
   1 2 3 4 5

2. This training will be beneficial to me in my performance at my job.
   1 2 3 4 5

3. The methods of content delivery (PowerPoints, etc.) were appropriate for this training.
   1 2 3 4 5

4. The training material was easy to understand and helpful.
   1 2 3 4 5

5. The topics were presented in a logical order.
   1 2 3 4 5

6. The vocabulary used in the training was clear and easy to understand.
   1 2 3 4 5

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

7. The instructor was knowledgeable and effective.
   1 2 3 4 5

8. The training covered the material I expected.
   1 2 3 4 5

9. The times scheduled for the agenda items were appropriate.
   1 2 3 4 5

10. This course met the objectives and my training needs.
    1 2 3 4 5

What comments/feedback do you have for this training? What worked and what didn't work?

How competent, or capable, do you feel in these different areas related to your job as Constant Observer in the Emergency Department?
**Please circle the best answer and be honest.

1. Organizational structure and relationships.
   1 2 3 4 5

2. Demonstrate effective interpersonal relations.
   1 2 3 4 5

3. Identify stakeholder needs/expectations.
   1 2 3 4 5

4. Sensitivity to what is appropriate behavior when communicating with diverse cultures, both internal and external.

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

1 2 3 4 5

5. Receive constructive feedback.
   1 2 3 4 5

6. Adhere to legal and regulatory standards.
   1 2 3 4 5

7. Foster an environment of mutual trust.
   1 2 3 4 5

8. Explore opportunities for the growth and development of the organization on a continuous basis.
   1 2 3 4 5

9. Anticipate and plan strategies for overcoming obstacles.
   1 2 3 4 5

10. Patient's rights and responsibilities.
    1 2 3 4 5

11. Consequences of unethical actions.
    1 2 3 4 5

12. Professional roles, responsibility, and accountability.
    1 2 3 4 5

13. Professional standards and codes of ethical behavior.
    1 2 3 4 5

14. Uphold and act upon ethical and professional standards.
    1 2 3 4 5

15. Adhere to ethical business principles.
    1 2 3 4 5

16. Healthcare and medical terminology.
    1 2 3 4 5

17. Physician, nurse, and BHCC roles.
    1 2 3 4 5

18. Constant Observer roles.
    1 2 3 4 5

19. The patient's perspective (e.g., cultural differences, expectations, psychopathology, etc.).
    1 2 3 4 5

20. Organization and delivery of healthcare.
    1 2 3 4 5

21. Standards of care.

1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

1 2 3 4 5

22. Evidence-based practice.
    1 2 3 4 5

23. Medical staff structure and its relationship to the governing body and facility operation.
    1 2 3 4 5

24. Organizational dynamics, political realities, and culture.
    1 2 3 4 5

25. Build trust and cooperation between/among stakeholders.
    1 2 3 4 5

26. Role and function of technology in operation.
    1 2 3 4 5

27. Confidentiality principles and laws.
    1 2 3 4 5

28. Corporate compliance laws and regulations.
    1 2 3 4 5

29. Patient rights, laws, and regulations.
    1 2 3 4 5

30. Risk mitigation.
    1 2 3 4 5

Appendix F

Provider Satisfaction Pre-Implementation Measure

Provider Satisfaction Survey **CO Intervention Program**

Constant Observer Service: Provider Satisfaction Survey

Age:

- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 and older

Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Gender not listed:________________

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latinx/Latino/Latina, or Spanish Origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or European American
- ☐ Another race/ethnicity not listed:_______________

What type of provider are you?

- ☐ Emergency Department Provider
- ☐ Nurse
- ☐ Medical Assistant
- ☐ Other _____________________

Utilization of Behavioral Health Consultation Services:

Approximately how many shifts per month include patients thatrequire a constant observer?

- ☐ 1-5
- ☐ 6-10
- ☐ 10+

Level of interest in clinical interventions for BH patients:

Overall, I am satisfied with the services delivered by the Constant Observers to my patients.

Strongly disagree			Neutral			Strongly agree
1	*2*	*3*	*4*	*5*	*6*	*7*

Provider Satisfaction Survey **CO Intervention Program**

There is a need for stabilized Behavioral Health patients awaiting placements to receive appropriately leveled clinical interventions.

Strongly disagree			Neutral			Strongly agree
1	*2*	*3*	*4*	*5*	*6*	*7*

The clinical interventions won't require the nursing staff to initiate or administer the interventions. However, the nursing staff would approve the initiation of the interventions and would support the linking of specific privileges (movies, music) to engagement in entry-level interventions.

I would support the incorporation of entry-level, evidenced-based interventions as appropriate for patients by communicating (e.g. *breathing app exercises to maintain emotional regulation and ACT Mindfully intervention videos with follow-up worksheets to facilitate mental health awareness*)

Strongly disagree			Neutral			Strongly agree
1	*2*	*3*	*4*	*5*	*6*	*7*

Patients will be more compliant with my medical recommendations after participating in entry-level behavioral health interventions facilitated by the COs.

Strongly disagree			Neutral			Strongly agree
1	*2*	*3*	*4*	*5*	*6*	*7*

I plan to see improvement in my patients' overall wellbeing as a result of behavioral health program.

Strongly disagree			Neutral			Strongly agree
1	*2*	*3*	*4*	*5*	*6*	*7*

Comments:

Appendix G

Provider Satisfaction Post-Implementation Measure

Evaluator: ________________ Evaluatee: GFU Behavioral Health Constant Obervers

Survey Purpose: We are interested in your feedback about the current Behavioral Health Constant Observer Intervention services provided by GFU.

Age:

- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 and older

Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Gender not listed:________________

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latinx/Latino/Latina, or Spanish Origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or European American
- ☐ Another race/ethnicity not listed:_______________

Using the following rating scale, circle the number that best reflects your response to each item regarding the George Fox Behavioral Health Constant Observer (CO) Service.

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

	1	2	3	4	5	NA
The GFU COs demonstrate the **knowledge** necessary to complete an effective, entry-level intervention program.						
The GFU COs demonstrate knowledge necessary to determine **if the patient was engaged with the intervention**.						
The CO demonstrates effective observation skills through **bi-directional communication** as needed.						
The GFU COs provide useful **written documentation** following monitoring.						
The intervention facilitated by the GFU CO is helpful in **reducing** patient problem behaviors.						

Evaluator: ________________ Evaluatee: GFU Behavioral Health Constant Obervers

Patients are more compliant with my medical recommendations after participating in entry-level behavioral health interventions facilitated by the COs						
I plan to see improvement in my patients' overall wellbeing as a result of behavioral health program.						
The GFU COs **collaborate** well with interprofessional team.						
The GFU COs conduct themselves professionally.						
The GFU COs **communicate** in a timely manner.						

What do you like best about the process?

What would you like to see improved?

Appendix H

Consent Form

Consent/Assent

Thank you for your participation in the Constant Observer and Behavioral Health Crisis Intervention program, and associated research through George Fox University. We are interested in exploring the effectiveness of the training curriculum related to the Behavioral Health Constant Observer program and the inclusion of interventions for individuals in crisis while awaiting psychiatric hospitalization.

INFORMATION

Involvement
Through participation in the Behavioral Health Crisis Intervention training program, you will be asked to complete a pre- and post-survey related to the training of the program. Data collected from the surveys will be used to increase the effectiveness of the training for future use.

Foreseeable risks or discomfort
Participation in this study involves no extra time commitment than that involved in the Constant Observer training process. Efforts will be made to protect identifying information, and the confidentiality of research participants.

Benefits
There is no financial compensation for participation in this study. However, the training and participation in this program are of educational benefit and opportunity.

Confidentiality
Confidentiality of personal information and data collected will be protected through use of participant ID numbers on forms collected, and with a separate secure file that contains the links between subject names and ID numbers. All electronic data will be password protected. Physical data (test protocols, forms) will be stored in a locked filing cabinet in a locked office.

Voluntary Involvement
Your agreement to allow this data that is being collected to be used for research purposes is voluntary. Refusal to participate will involve no penalty or loss of program benefits to which the crewmember is otherwise entitled. You may also discontinue participation at any time up until data analyses are completed.

AGREEMENT

I, the undersigned, agree to participate in intervention training for Behavioral Health Crisis Intervention in the Emergency Department of Providence Newberg Medical Center. I also agree to complete a series of pre- and post-questionnaires related to the Constant Observer training program.

I understand that this information is being gathered for research purposes, and that the person gathering the information will protect my identity and privacy in any and all ways in which this information is used.

I understand that I may stop my involvement at any point, with no explanation necessary. If I have any questions that the person administering the surveys cannot answer or concerns about the testing process, I can contact Dr. Celeste Jones of the George Fox University Graduate Department of Clinical Psychology. Dr. Celeste Jones is available at cjones@georgefox.edu or (503) 554-2384.

I understand that I will receive a copy of this consent and by signing indicate that I am at least 18years of age and understand and accept the conditions described above.

____
Participant Printed Name

______________________________ ______________
Participant Signature *Date*

______________________________ ______________
Examiner's Signature *Date*

Appendix I

Curriculum Vitae

COLTEN WAYNE LARSEN, MA

Curriculum Vitae
Pronouns: *he/him/his*

EDUCATION

Present	**Doctor of Psychology in Clinical Psychology** *(APA Accredited)* ***Anticipated Graduation May 2022*** George Fox University, Newberg, OR Academic Advisor: Celeste Jones, PsyD, ABCCAP Defended Dissertation Title: *Behavioral Health Crisis Intervention for Emergency Department Patients Pending Psychiatric Hospitalization* Committee: Celeste Jones, PsyD, ABCCAP (chair), Mary Peterson, PhD, ABPP, Luann Foster, PsyD
2019	**Master of Arts in Clinical Psychology** *(APA Accredited)* George Fox University, Newberg, OR Academic Advisor: Celeste Jones, PsyD, ABCCAP
2016	**Master of Arts in Forensic and Legal Psychology** Marymount University, Arlington, VA Academic Advisor: Angel Daniels, PhD
2014	**Bachelor of Arts in Psychology**, *Cum Laude* Whitworth University, Spokane, WA *Minor*: Theatre, costuming emphasis Academic Advisor: Melissa Rogers, PhD Senior Thesis: *The Role of Comparison: How Intrinsically and Extrinsically Motivated Students Respond to Being Compared to Others*

SUPERVISED CLINICAL EXPERIENCE

Aug 2020—Present	***Pre-Internship: Assessment Examiner & Pediatric Liaison*** George Fox Behavioral Health Center, Assessment Clinic, Newberg, OR Supervisor(s): Paul Stoltzfus, PsyD; Glena Andrews, PhD, MSCP, ABPP; Kenneth Logan, PsyD

Description:
- Administer psychodiagnostic, psychoeducational, and neuropsychological assessments to individuals throughout the lifespan (primary focus on children/adolescents) in a community-based, behavioral health setting
- Score, interpret, and write assessment results in integrated reports
- Provide in-person assessment consultation and outcome feedback
- Participate in group supervision with licensed psychologist, including the facilitation of didactic training
- Provide supplemental therapy/cognitive rehabilitation to one long-term client, age 12, with Fetal Alcohol Syndrome, Reactive Attachment Disorder, Tic Disorder, and ADHD (per hx)
- Continue as liaison for Newberg Pediatrics behavioral health management, actively engage in ongoing pediatrician consultation (Shannon Brigman, MD), assign and coordinate assessment and therapy cases to doctoral practicum and supplemental practicum students, and provide supplemental supervision to doctoral students completing pediatric assessment evaluations

Aug 2020—Present

Fourth Year Mentor
Graduate School of Clinical Psychology, George Fox University, Newberg, OR
Supervisor: Rodger Bufford, PhD
Description:
- Provide weekly supplemental oversight and mentorship to 2nd year PsyD student
- Oversee clinical work with an emphasis on case conceptualization, intervention, and assessment interpretation
- Cultivate professional development and clinical competencies

Jan 2020—July 2020

Supplemental Practicum: Assessment Examiner
Newberg Pediatrics/George Fox Behavioral Health Assessment Clinic, Newberg, OR
Supervisor: Glena Andrews, PhD, MSCP, ABPP; Kenneth Logan, PsyD
Description:
- Administer psychodiagnostic, psychoeducational, and neuropsychological assessments to individuals ages 5-18 for diagnostic clarification, academic support eligibility, and treatment recommendations
- Interpret psychological tests and write integrated reports
- Participate in pediatrician consultation (Shannon Brigman, MD)

and provide testing outcome feedback with parents and other providers

Aug 2019—July 2020

Practicum II: Doctoral Psychology Trainee
Oregon State Hospital, Salem, OR
Geriatric/Neuropsychology Unit—Butterfly 2, Springs Program
Supervisor(s): Sabine Hyatt, PhD; Sarah Robertson, PhD
Description:

- Provide care and treatment to older adults with severe and persistent mental illness (SPMI), traumatic brain injuries, and disease processes known to affect the central nervous system
- Administer neuropsychological and psychological assessments, interpret outcomes, and write integrated reports for diagnostic clarification and treatment recommendations
- Co-facilitate group therapy involving cognitive tasks addressing particular cognitive domains and competency restoration (Brain Games) and provide legal skills curriculum for patient aid and assist competency restoration (Legal Skills)
- Participate in interdisciplinary consultation and attend patient treatment meetings with psychiatry, psychology, nursing, social work, behavioral health services, and other disciplines
- Attend monthly didactics for continuing education
- Participate in telehealth patient consultation following COVID-19 pandemic

Jan 2018—Present

Supplemental Practicum: Forensic Psychology Student Trainee
Forensic Psychological Services (Private Practice), Newberg, OR
Supervisor: Patricia Warford, PsyD
Description:

- Attend psychological service meetings in correctional facilities and private practice in Washington County, Multnomah County, Linn County, Lane County, Clackamas County, Yamhill County (including FCI Sheridan)
- Assist psychologist in forensic evaluations and other evaluations (*i.e.* aid-and-assist, mitigation, criminal responsibility, etc.) for adults and juveniles
- Assist psychologist in forensic evaluations of high profile cases
- Administer psychological and forensic assessments to a range of individuals involved in the judicial system
- Extensively review case documentation, including legal records, surveillance footage, medical records, etc.
- Write de-identified forensic reports and participate in “mock trials” with psychologist and other trainees

Jan 2018—May 2020

Supplemental Practicum and Professional Experience: Behavioral Health Crisis Consultant

Behavioral Health Crisis Consultation Team, Yamhill County, OR
Supervisor(s): Luann Foster, PsyD; Mary Peterson, PhD, ABPP; William Buhrow, PsyD
Description:

- Provide crisis consultation at emergency departments in local hospitals
- Perform risk assessments regarding suicide/homicide, psychosis, and other behavioral health evaluations
- Consult and collaborate with medical staff and other integrated health professionals
- Attend weekly group supervision and didactics
- Collaborate with other team members and supervisors
- Aid in training for new crisis consultants
- Participate in telehealth patient consultation following COVID-19 pandemic

Aug 2018—May 2019 ***Practicum I: Therapist & Psychological Evaluator***
Rural Child and Adolescent Psychological Services, St. Paul, OR
Supervisor(s): Elizabeth B. Hamilton, PhD; Andrew Kenagy, PsyD; Lynsey Fringer, MA
Description:

- Provide individualized psychotherapy to middle school and high school students in a rural area
- Provide group workshops and group therapy to middle school and high school students in a rural area
- Teach 10-week class based on The Healthy Lifestyle Choices program (CDC & SHER) to 7th and 8th grade students through Providence Medical Group grant
- Consult and collaborate with school staff and other interdisciplinary professionals
- Administer psychological assessments, interpret outcomes, and write integrated reports regarding student individualized education plans
- Program outreach for suicide awareness to middle schoolers and high schoolers
- Work with a language interpreter in providing feedback to parents of children receiving IEP testing, as well as establishing care for students

Jan 2018—April 2018 ***Pre-Practicum: Student Therapist***
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisor(s): Glena Andrews, PhD, MSCP, ABPP; Andrew Summerer, MA
Description:

- Provide outpatient, individual, client-centered psychotherapy

services to volunteer undergraduate students
- Conduct intake interviews, write treatment plans, make diagnoses, write professional reports, and make case presentations
- Consult with supervisors and members of clinical team
- All sessions video-taped, reviewed extensively, and discussed in individual and group supervision

RELATED PROFESSIONAL EXPERIENCE

June 2016—Aug 2017

Habilitative Intervention Professional *(Applied Behavioral Analysis)*
Progressive Behavior Systems, Twin Falls, ID
Supervisor: Moriah Fowler-Dietrich, HI, Director of Services
Description:
- Work individually with children ages 3-17 with Developmental Disabilities, as well as mental health disorders such as Oppositional Defiant Disorder, Conduct Disorder, and Schizophrenia
- Implement Applied Behavior Analysis techniques to improve the child's adaptive skills, discourage problem behaviors, develop replacement behavior, increase socially responsible abilities, and improve functional skills
- Work closely/collaborate with parents, therapists, school officials, and other professionals
- Develop treatment plans and administer skills assessments
- Participate in IEP meetings with an interdisciplinary team

Jan 2016—May 2016

Juvenile Court Intern
Arlington Juvenile and Domestic Relations District Court Unit Services, Arlington, VA
Supervisor(s): Lacretia Davis, PO; Earl Conklin, Director of Juvenile Court Services
Description:
- Assist parole officer with probation and parole cases
- Visit youths in rehabilitation centers and detention
- Attend court hearing and advisory notes
- Maintain causal files and contact logs
- Correspond with youth and their families
- Participate in juvenile psychological training provided by court psychologist

Jan 2014—July 2014

SPO Intern
Spokane Police Ombudsman, Spokane, WA
Supervisor: Tim Burns, *Former* Ombudsman
Description:

- Provide information or refer citizens to public/private agencies or community services
- Assist in addressing citizen complaints regarding police actions and services
- Perform descriptive and multivariate statistical analyses of data using SPSS regarding Use of Force
- Collaborate with city officials

Oct 2013—Dec 2013 | ***Psychology of Poverty Volunteer***
Northeast Youth Center, Spokane, WA
Supervisor: Patricia Bruininks, PhD
Description:
- Maintain a safe play environment
- Observe and monitor children's play activities
- Support children's emotional, behavioral, and social development

PROGRAM DEVELOPMENT & EVALUATION

Sept 2018—June 2020 | ***Project Manager***
Emergency Department Behavioral Health Crisis Protocol
Providence Newberg Medical Center
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisor: Mary Peterson, PhD, ABPP
Duties:
- Collaborate with multiple teams to train and mentor staff in achieving the mission and goals of the project
- Discuss needs and requirements with beneficiaries
- Develop program plans and schedules
- Develop protocol for a multidisciplinary team
- Develop outcome measures of training satisfaction/competency and program satisfaction
- Assess program efficiency
- Assist in training behavioral health professionals and medical staff to meet the needs of program and health system
- Attend meetings with hospital officials and medical providers to facilitate the implementation process of the program

CONSULTATION & REVIEWS

Aug 12, 2020 | ***Consultant*** with Elisabeth Owen, MA, QMHP
Behavioral Health Crisis Consultation Team
Yamhill County Mental Health
Graduate School of Clinical Psychology

George Fox University, Newberg, OR
Topic: Transgender Healthcare within the Emergency Department

Sept 2019—May 2020

Consultant with Elisabeth Owen, MA, Lauren Abshire, MA
Topic: Transgender Healthcare/Working with Transgender Clients in the Judicial System
Supervisor(s): Marie-Christine Goodworth, PhD; Mary Peterson, PhD; Amber Nelson, PsyD
Supplemental supervisor(s): Jeri Turgesen, MSCP, PsyD; Patricia Warford, PsyD
In consultation with:

- Providence Newberg Medical Center, Internal Medicine
- Providence Newberg Medical Center, Family Medicine
- Metropolitan Public Defender, Hillsboro, OR Law Office
- Metropolitan Public Defender, Portland, OR Law Office

TEACHING & ACADEMIC APPOINTMENTS

Aug 2020—Present

Clinical Foundations Teaching Assistant
PSYD 530/531 Clinical Foundations I & II
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor/Supervisor: Aundrea Paxton, PhD
Duties:

- Aid in the organization and structure of course
- Aid in the teaching and practice of basic therapeutic skills for 1st year PsyD students in the Rogerian, client-centered modality, specifically in interpersonal communication and empathy skill building using role play techniques and video/audio feedback
- Aid in the teaching of ethical issues of practice, the administrative structure and functioning of clinical settings, and the practical issues of assessment, psychotherapy, case management, and record keeping
- Facilitate weekly meetings and ***closely supervise*** five 1st year PsyD students in simulated clinical therapy experience while integrating course theory and practice
- Participate in weekly supervision with licensed psychologist regarding student-on-student clinical supervision

March 11, 2020

Advanced Member Didactic Presenter
Behavioral Health Crisis Consultation Team
Yamhill County Mental Health
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Topic: *Forensic Commitment and Violence Risk Assessment*

February 28, 2020

Guest Lecturer
PSYD 521 Personality Assessment
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Topic: *Ethics in Assessment*
Professor: Kenneth A. Logan, PsyD

Spring 2020

Teaching Assistant
PSYD 521 Personality Assessment
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Kenneth A. Logan, PsyD
Duties:

- Aid in the organization and structuring of the course
- Aid in the teaching and practice of individualized assessment of personality (*i.e.* MMPI-2, PAI, MCMI, 16PF)
- Facilitate meetings with students for additional help on assessment interpretation and report writing standards
- Aid in grading of student assignments based on APA standard of competency in test administration, test scoring, and testing interpretation, including report writing

Fall 2019

Teaching Assistant
PSYD 522 Cognitive Assessment
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Kenneth A. Logan, PsyD
Duties:

- Aid in the organization and structuring of the course
- Aid in the teaching and practice of individualized assessment of intellectual and other selected cognitive functions (*i.e.* WAIS-IV, WISC-V, WIAT-III, WMS-IV)
- Facilitate weekly lab group meetings and ***supervision*** with students for administration practice and continued support in course
- Attend weekly meetings with course professor and other teaching assistants to address student concerns and course components
- Participate in meetings with other teaching assistants to address strict grading criteria for APA competency in test administration, test scoring, and testing interpretation and facilitate internal grading consistency

June 6, 2019

Guest Lecturer
GCEP 567 Cultural Foundations and Social Justice

Graduate Counselor Education Program
George Fox University, Portland, OR
Topic: *Heterosexism, Transgender Oppression, and LGBTQ+ Issues*
Professor: Lanaya Wade, MA, QMHP

Spring 2019 — ***Teaching Assistant***
PSYD 509 Biological Basis of Behavior
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Celeste Jones, PsyD, ABCCAP
Duties:
- Assist professor with classroom structure and organization
- Assist in finding current, relevant research for class instruction
- Structure and prepare lectures based on new material relevant to class topic

April 16, 2018 — ***Guest Lecturer*** with Celeste Jones, PsyD, ABCCAP
HLTH 320 Contemporary Health Issues
Department of Health and Human Performance
George Fox University, Newberg, OR
Topic: *Adolescent Suicidality and Risk*
Professor: Byron Shenk, Athletic Trainer (retired)

Spring 2013 — ***Teaching Assistant***
PY 345 Forensic Psychology
Psychology Department
Whitworth University, Spokane, WA
Professor: Melissa Rogers, PhD
Duties:
- Assist professor with classroom instruction, exams, and record keeping
- Tutor/mentor students
- Prepare and deliver lectures

Fall 2013 — ***Teaching Assistant***
PY 241 Social Psychology
Psychology Department
Whitworth University, Spokane, WA
Professor: Mark Baird, PhD
Duties:
- Assist professor with classroom instruction, exams, and record keeping
- Tutor/mentor students
- Prepare and deliver lectures
- Provide feedback and further assistance to new faculty

Fall 2013

Teaching Assistant
PY 101 Introduction to Psychology
Psychology Department
Whitworth University, Spokane, WA
Professor: Joelle Czirr, MA, LMFT
Duties:

- Assist professor with classroom instruction, exams, and record keeping
- Tutor/mentor students
- Prepare and deliver lectures

Spring 2012

Teaching Assistant
PY 210 Developmental Psychology
Psychology Department
Whitworth University, Spokane, WA
Professor: Noel Wescombe, PhD (†)
Duties:

- Assist professor with classroom instruction, exams, and record keeping
- Tutor/mentor students
- Assist professor in constructing an interactive developmental psychology e-book

RESEARCH EXPERIENCE & PARTICIPATION

2018—Present

Dissertation Research
(Also see Program Development and Evaluation section above)
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Committee Members: Celeste Jones, PsyD, ABCCAP (chair), Mary Peterson, PhD, ABPP, Luann Foster, PsyD
Title: Behavioral Health Crisis Intervention for Emergency Department Patients Pending Psychiatric Hospitalization
Successfully Defended with Full Pass: December 15, 2020

2018—Present

Research Vertical Team Member
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Chair: Celeste Jones, PsyD, ABCCAP
Research: meet bi-monthly to discuss and evaluate progress, methodology, and design of group and individual research projects, including dissertation.
Areas of team focus: child and adolescent psychology; child and adolescent treatment and assessment; risk assessment; juvenile, forensic populations; autism spectrum disorder; developmental

disabilities; young adult women.
Specific personal interests: youth and young adults with disruptive behavior disorders, specifically with limited prosocial/callous-unemotional traits, juvenile recidivism, juvenile sex offending, autism and other developmental disabilities within the judicial system, diverse and high-risk populations within the judicial system, resilience, forensic evaluation, LGBTQ+ issues, and program development and evaluation.

2015—2017 ***Research Assistant***
Sexual Assault, Violence, and Exploitation Research Group (SAVE)
Forensic and Legal Psychology Department
Marymount University, Arlington, VA
Supervisor: Angel Daniels, PhD
Research: provide research, education and training, and consultation on the issues of sexual abuse, sexuality, violence, and exploitation.

Jan 2014—July 2014 ***SPO Intern***
Spokane Police Ombudsman, Spokane, WA
Supervisor: Tim Burns, (former) Ombudsman
Research: analyze Use of Force forms completed by Spokane police officers on the number of incidences officers utilized firearms, electroshock weapons, SWAT teams, and K-9 Units during high-risk incidents and contributing information to the Spokane *Office of Police Ombudsman 2014 Mid-Year Report*, presented to the mayor and chief of police.

RESEARCH PRESENTATIONS

Larsen, C.W., Owen, E., Hamilton, S., Grace, E., Jones, C., & Peterson, M. (2019). *Behavioral health crisis intervention for adolescent emergency department patients pending psychiatric hospitalization.* Poster presented at the American Psychological Association Annual Convention, Division 53, Chicago, IL, August 2019.

Larsen, C.W., Flint, A. (2013). *The role of comparison: How intrinsically and extrinsically motivated students respond to being compared to others.* Presented at the Annual Whitworth Undergraduate Research Conference, Spokane, WA, December 2013.

ASSESSMENT COMPETENCY, EXPERIENCE, & EXPOSURE

(*Trained-in and/or competency obtained without formal administration for clinical purposes)

Parent/Youth-Report Measures
- Behavioral Assessment System of Children—Third Edition

Symptom Inventories
- Beck Anxiety Inventory*
- Beck Depression Inventory*
- Beck Youth Inventories of Emotional and Social Impairment*
- Generalized Anxiety Disorder 7-Item Scale
- Patient Health Questionaire-9
- Symptom Checklist-90-Revised

General Cognitive Assessments
- Comprehensive Test of Nonverbal Intelligence—Second Edition*
- Wechsler Abbreviated Scale of Intelligence*
- Wechsler Adult Intelligence Scale—Fourth Edition
- Wechsler Adult Intelligence Scale—Fourth Edition—iOS Version
- Wechsler Intelligence Scale for Children—Fifth Edition
- Wechsler Intelligence Scale for Children—Fifth Edition—iOS Version
- Wechsler Nonverbal Scale of Ability
- Wide Range Intelligence Test*
- Woodcock-Johnson Tests of Cognitive Abilities—Fourth Edition
- Test of Nonverbal Intelligence—Fourth Edition*

Neuropsychological Assessment Measures
- Behavior Rating Inventory of Executive Function—Second Edition
- Behavior Rating Inventory of Executive Function for Adults
- Booklet Categories*
- Boston Aphasia Test*
- Boston Naming Test*
- California Verbal Learning Test—Children's Version
- California Verbal Learning Test—Second Edition
- California Verbal Learning Test—Third Edition
- Children's Memory Scale
- CLOX: An Executive Clock Drawing Test*
- Controlled Oral Word Association Test*
- Delis—Kaplan Executive Function System
- F-A-S Test*
- Grooved Pegboard
- Modified—Wisconsin Card Sorting Test
- Montreal Cognitive Assessment
- NEPSY—Second Edition
- Neuropsychological Assessment Battery—All Modules
- Peabody Picture Vocabulary Test*
- Repeatable Battery of Assessment of Neuropsychological Status

- Rey 15 Item Test*
- Rey-Osterrieth Complex Figure Test and Recognition
- Saint Louis University Mental Status*
- Sensory Profile
- Tactual Performance Test*
- Test of Premorbid Functioning
- The Dot Counting Test*
- Trail Making Test A&B
- Wechsler Memory Scale—Fourth Edition*
- Wisconsin Card Sorting Test
- Wisconsin Card Sorting Test—Computer Version

Measures of Academic Functioning
- Adult Dyslexia Screener*
- Gray Oral Reading Test—Fifth Edition
- Jordan Left-Right Reversal Test—Third Edition
- Wechsler Individual Achievement Test—Third Edition*
- Wide Range Achievement Test—Fourth Edition*
- Woodcock-Johnson Test of Achievement—Fourth Edition
- Test of Reading Comprehension—Fourth Edition
- Test of Word Reading Efficiency—Second Edition*

Behavioral/Personality Measures
- Adaptive Behavior Assessment System—Third Edition
- Autism Spectrum Rating Scales
- Child Behavior Checklist
- Clinical Assessment Scale for the Elderly
- Conners—Third Edition
- Jesness Inventory—Revised
- Millon Adolescent Clinical Inventory*
- Millon Clinical Multiaxial Inventory—Fourth Edition*
- Millon Pre-Adolescent Clinical Inventory
- Minnesota Multiphasic Personality Inventory—2
- Minnesota Multiphasic Personality Inventory—2–Restructured Form*
- Minnesota Multiphasic Personality Inventory—Adolescent
- Personality Assessment Inventory
- Personality Assessment Inventory—Adolescent
- Sensory Profile
- Sixteen Personality Factor Questionnaire*

Forensic/Risk Assessments
- Columbia-Suicide Severity Rating Scale
- Competence Assessment for Standing Trial for Defendants with Mental Retardation*
- Estimate of Risk Adolescent Sexual Offense Recidivism*
- Hare Psychopathy Checklist—Revised
- Historical Clinical Risk Management-20—Third Version

- Gudjonsson Suggestibility Scale*
- Inventory of Callous-Unemotional Traits*
- Inventory of Legal Knowledge
- Juvenile Sex Offender Assessment Protocol—Second Edition*
- Short-Term Assessment on Risk and Treatability
- Static-99*
- The MacArthur Competence Assessment Tool—Criminal Adjudication*
- The Miranda Rights Comprehension Instruments*

Measures of Malingering

- Structured Interview of Reported Symptoms—Second Edition*
- Test of Memory Malingering

Projective Assessments

- House-Tree-Person Test*
- Roberts Apperception Test for Children—Second Edition

PROFESSIONAL AFFILIATIONS

2019—Present Division 53, Society of Clinical Child and Adolescent Psychology (Student Member)

2017—Present Division 41, American Psychology-Law Society (Associate-at-Large)

2015—Lifetime Psi Chi, Psychology Honors Society (member)

2014—Present American Psychological Association (Graduate Student Affiliate)

RELEVANT MEMBERSHIPS & PARTICIPATION

2019—Present Forensic Psychology Student Interest Group (member)
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

2017—Present Gender, Sexuality, and Identity Student Interest Group (member)
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

2018—2019 Graduate School of Clinical Psychology (Second Year Mentor)
George Fox University, Newberg, OR

2017—2019 Forensic Psychology Student Interest Group (co-leader)
Graduate School of Clinical Psychology

	George Fox University, Newberg, OR
Spring 2016	Forensic and Legal Psychology Department's staged reading of *The Exonerated* by Jessica Blank and Erik Jensen (actor/researcher) Marymount University, Arlington, VA
Fall 2013	House of Charity Homeless Shelter (Urban Plunge participant) Psychology Department Whitworth University, Spokane, WA
2012—2013	Whitworth Mentoring Program (Freshman Mentor) Whitworth University, Spokane, WA
2010—2014	Gay Straight Alliance Club (member) Whitworth University, Spokane, WA

ATTENDED COLLOQUIUM & GRAND ROUNDS

Justin Lee, PhD. *Pediatric cancer and the psychology of oncology and hematology.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 14, 2020.

Amy Stoeber, PhD. *Mitigating the effects of ACES and transforming primary care through resilience building and compassionate connection.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 12, 2020.

Cheryl Forster, PsyD. *Intercultural prerequisites for effective diversity work.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 15, 2019.

Everett L. Worthington, Jr., PhD. *Promoting forgiveness.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. September 25, 2019.

Douglas Marlow, PhD. *Marital therapy and the Gottman standard.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. March 20, 2019.

Diomaris Safi, PsyD & Alexander Millkey, PsyD. *Opportunities in forensic psychology.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 13, 2019.

Scott Pengelly, PhD. *Old pain in new brains.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 10, 2018.

Lisa McMinn, PhD & Mark McMinn, PhD. *Spiritual formation and the life of a psychologist: Looking closer to soul-care.* Colloquium, Graduate School of Clinical Psychology, George

Fox University, Newberg, OR. September 26, 2018.

Michael Vogle, PsyD. *Integration and ekklesia.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. March 14, 2018.

Carlos Taloyo, PhD. *The history and application of interpersonal psychotherapy*. Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 14, 2018.

Jeffery Sordahl, PsyD. *Telehealth*. Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. November 08, 2017.

Eleanor Gil-Kashiwabara, PsyD. *Community based participatory research and tribal participatory research with Indian American/Alaskan Natives*. Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 11, 2017.

ADDITIONAL PROFESSIONAL TRAINING, EDUCATION, & ATTENDED PRESENTATIONS

Kathie O. Berger, Kristen Machiewicz Seghete, PhD, Laura Zorich, PsyD, Debbi Martin, Policy Advisor, & Heber Bray, Sr., Policy Advisor. *Juvenile waiver training.* Northwest Forensic Institute, Continuing Education Training, Portland, OR. July 10, 2020.

APA, *Annual American Psychological Association Convention 2019*. August 8-11, 2019. Chicago, IL.

Attended symposium topics include:

- Sex education related to LGBTQ+ issues
- Increased legal system involvement for people with mental illnesses
- Suicidology and behavioral health
- Psychological assessments and the legal system

Chloe Ackerman, PsyD. *Transgender health and care.* Diversity of Gender and Sexuality Student Interest Group, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. April 17, 2019.

APA, Division 41. *American Psychology-Law Society Annual Conference 2019—50th Anniversary*. March 14-16, 2019. Portland, OR.

Attended symposium topics include:

- Psychopathy and theoretical models, including the HEXACO and Triarchic model
- LGBTQ+ involvement within the judicial system
- Forensic assessment and evaluation
- The Innocence Project and exonerated individuals
- Juvenile justice
- Rapid Fitness to Proceed Program (Oregon)
- Developmental disabilities within the justice system

Stefanie Varga, PhD, LP & Rebecca Jorgensen, PsyD, LP. *Hidden in the system: Screening,*

identification, and assessment of special populations in the juvenile and adult justice system. American Psychology-Law Society Annual Conference, 3-hour continuing education pre-workshop. Portland, OR. March 13, 2019.

Patricia Warford, PsyD. *Forensic report writing and psychological testing.* Newberg, OR. November 30, 2018.

Octavio Choi, MD, PhD. *Real-life monsters: Psychopathy and the neuroscience of morality.* Portland, OR. October 30, 2018.

Jennifer Andrashko, MSW, LICSW & Kimberly Sommers, PsyD, LP. *Ethics and boundaries in rural America: A practical approach.* Newberg, OR. October 5, 2018.

CERTIFICATIONS AND LICENSES

October 2020 — Telehealth: Legal and Ethical Issues
Certificate of Completion
Instructor: Benjamin E. Caldwell, PsyD, LMFT
SimplePractice Learning

Summer 2020 — Neuroanatomy
Certificate of Completion
Instructor: Glena Andrews, PhD, MSCP, ABPP
Graduate School of Clinical Psychology
George Fox University

2018—2020 — Qualified Mental Health Professional
Yamhill County, Oregon

2016—2018 — Habilitative Intervention Certification (*Applied Behavioral Analysis*)
State of Idaho

HONORS & AWARDS

Spring 2019 (*coordinator & recipient*) — Forensic Interested Student, 2019 AP-LS Conference Stipend
Graduate School of Clinical Psychology
George Fox University

2019 — Psychology Department Featured Alumni
Whitworth University
Found at: https://issuu.com/whitworth/docs/career-booklet-2019

2012—2014 — Whitworth Theater Department Talent Award for Costume Design
Whitworth University

2011—2012 — Honors Award

	Whitworth University
2010—2014	Whitworth Academic Scholarship Whitworth University
2010—2014	Legacy Scholarship Whitworth University

OFFICES HELD

2020—Present	*Vice President* Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR
Jan 2020—May 2020	*Small Group Leader* Behavioral Health Crisis Consultation Team Graduate School of Clinical Psychology George Fox University, Newberg, OR
2019—2020	*Student Wellness Committee Coordinator* Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR
2019—Present	*Class of 2022 Cohort Representative* Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR
2018—2019	*StuCo Coordinator Support* Student Wellness Committee, Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR
2018—2019	*Member-at-Large* Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR
2013—2014	*Public Relations Manager* Gay Straight Alliance Club Whitworth University, Spokane, WA