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Solution-Focused Brief Therapy (SFBT) Training and Implementation in Integrated Care Settings:
Pilot Initiative Evaluation

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Executive Summary

This report details the procedures and preliminary outcomes from the Illinois Behavioral Health Workforce Center (BHWC) Solution-Focused Brief Therapy (SFBT) Training and Implementation Pilot Initiative for Integrated Care Settings. Integrated care involves the co-location and coordination of medical and behavioral health care with the goal of promoting timely access to behavioral health services when mental health-related needs are identified by medical providers. Typically, behavioral health services provided in integrated care settings involve shorter and fewer sessions than ordinary community mental health services, warranting provider training on evidence-based brief therapies suitable for integrated care. SFBT is a strengths-based and client-centered approach focused on using existing strengths to work toward a preferred future, and its solution-focused design can allow for a quicker change process by avoiding lengthy assessments of existing problems.

The pilot initiative involved 12 integrated care agencies from across the state of Illinois that received funds for training and implementation activities for the use of SFBT in integrated care. Half of the agencies were randomly assigned to an additional local champion component involving the development of a local SFBT expert to provide internal consultation and support on SFBT implementation. In total, 49 providers received SFBT training through the initiative. The outcomes of the initiative were assessed using surveys, client evaluation forms, focus groups, and agency reports on SFBT implementation.

Two main areas were assessed regarding the outcomes from the pilot initiative: 1) The appropriateness of SFBT for integrated care settings and 2) The benefits and suitability of the local champion implementation component. Key findings of the pilot initiative evaluation include:

- Providers gave **high ratings for the appropriateness, acceptability, and feasibility** of using SFBT in integrated care settings.
- Providers reported **needing shorter sessions and fewer sessions when using SFBT** compared to other approaches. *For an average investment of $2,418 per provider, the pilot initiative showed that providers using SFBT could help clients see meaningful change in an average of 2.75 fewer sessions.*
- Client evaluation data showed that using **SFBT was associated with clients' self-report of decreased distress and increased goal clarity over the course of one session,** especially with stronger fidelity to the SFBT model.
- Focus groups and agency final reports suggested that **SFBT may have benefits for reducing provider burnout and promoting retention that should be explored further** in future data collection evaluating the SFBT Initiative.

- The benefits of training one provider to serve as an SFBT champion were mixed, with no significant benefits in comparison to the group that did not receive champion support in most areas. The lack of a positive effect could be due to additional support provided in non-champion sites to support the intervention.

These findings support continued investment in the dissemination of SFBT in integrated care settings to meet the need for accessible, effective interventions across Illinois. Given the increased costs of developing a local champion, further evaluation is warranted regarding the long-term sustainability of SFBT implementation with and without champions or another support for the use of the intervention. While champions were not found to have strong effects on use of the intervention, focus group findings indicate that agency support of some type is critical for strong implementation. In FY25, the effects of learning collaboratives, which may be more cost-effective, will be studied to better understand their potential to support ongoing use of SFBT.

Introduction

The Behavioral Health Workforce Center of Illinois (BHWC) aims to increase access to effective behavioral health care for residents throughout the state through supporting the recruitment, training, and retention of the professionals who provide care. Among the primary goals of the BHWC is to promote availability of behavioral health services in easily accessible settings such as integrated care settings where behavioral health is co-located within primary care or other medical settings. In the first two years of funding, the BHWC at the Jane Addams College of Social Work was primarily focused on data collection and training initiatives. The integrated care initiative specifically focused on training needs of behavioral health providers in integrated care settings.

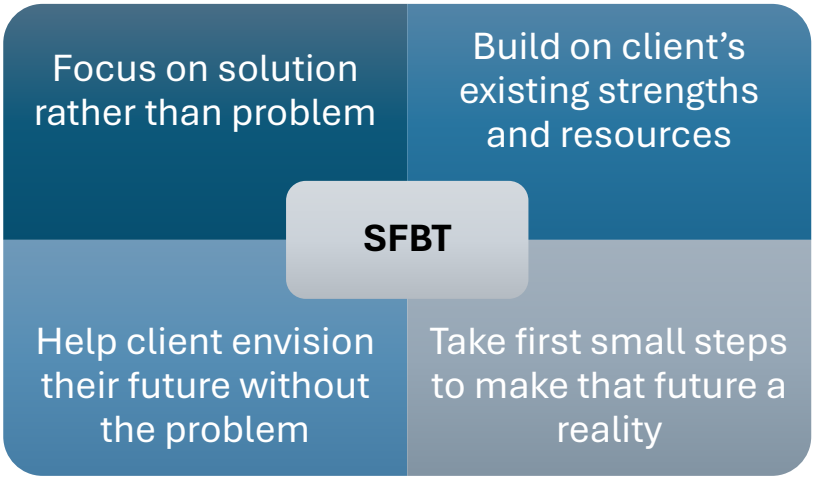
> ***"Primary goals of the statewide Behavioral Health Workforce Education Center are to strengthen the behavioral healthcare system in Illinois through initiatives targeting the following:...Increase the capacity of behavioral health providers and medical staff to meet the population's behavioral health needs in easily accessed settings such as primary care..."***
>
> **BHWC First Report to the Illinois General Assembly (2023)**

Integrated care consisting of co-location of behavioral health and medical care services offers unique opportunities and challenges for behavioral health providers (Dobmeyer et al., 2016). Integrated care can offer immediate access to a provider via warm handoff when a behavioral health need is identified by a medical provider and typically involves shorter interactions and fewer sessions than traditional community mental health services (Hostutler et al., 2023; Vogel et al., 2017). Given these constraints, effective brief interventions are important for maximizing the benefit of behavioral health services in integrated care. To help promote improved quality, efficiency, and access to behavioral health care via integrated care settings, the BHWC Integrated Care initiative convened an advisory group of integrated care providers and leaders from across the state in Spring 2023 to inform the development of a pilot training initiative targeting effective brief intervention in integrated care settings. Guided by the advisory group feedback and research evidence, solution-focused brief therapy (SFBT) was selected as the focus of the pilot initiative.

SFBT is an evidence-based brief therapy suited for medical settings that offers a strengths-based and client-centered approach to addressing behavioral health needs (Kim et al., 2019; Zhang et al., 2018). Drawing from a systemic perspective, SFBT assumes that clients are already engaging in a change process and that they have the strengths, resources, and creativity to develop their own solutions (de Shazer et al., 1986, 2021). Figure 1 shows

several key principles of SFBT, including the emphasis on exploring the client's preferred future rather than attempting to understand the cause of their problems, building on the client's existing strengths and resources, and helping them to identify the first small steps they can take to make that future a reality (Lee & Eads, 2024). By aligning with an existing change process and avoiding lengthy clinician-driven assessment, SFBT has the potential to move toward meaningful change more quickly than more problem-focused approaches.

Figure 1. Principles of Solution-Focused Brief Therapy



Though SFBT is supported by a large base of evidence regarding its effectiveness (Neipp & Beyebach, 2024), there is a gap in the literature regarding the best way to implement SFBT in integrated care settings. When providing training in a new therapy approach, two key outcomes of interest for an implementation initiative include adoption—the extent to which providers actually use the new approach—and fidelity—how well the intervention actually delivered matches the intended design and techniques of the therapy model (Proctor et al., 2011). Training alone is generally less effective than a more comprehensive implementation approach (Frank et al., 2020; Strifler et al., 2020). The development of a local "champion" who advocates for and guides implementation of a new practice has been identified as helpful (Flanagan et al., 2018; Morena et al., 2022), but local champions have not previously been evaluated for implementation of SFBT in integrated care settings.

This report presents a pilot evaluation of the initial round of the BHWC SFBT Training and Implementation Initiative conducted from January to June 2024. The report includes general outcomes of the initiative from provider surveys, provider focus groups, and a 2-week client evaluation phase, and also provides comparison of implementation outcomes from participating agencies randomly assigned to receive an additional "local champion" component versus agencies that received only the standard implementation protocol.

Methods

The pilot phase of the SFBT Training and Implementation Initiative sought to determine the feasibility and outcomes of SFBT implementation in integrative care settings to inform further rollout of SFBT training in Illinois as indicated by the findings. In August 2023, a Request for Proposals (RFP) was distributed to invite integrated care sites throughout the state to apply for funding from BHWC to train their behavioral health providers in integrated care in SFBT, with implementation support provided by BHWC (see Appendix A). A leading trainer in SFBT was selected to provide live virtual trainings throughout the initiative.

In total, 18 agencies submitted applications for the BHWC funding for the SFBT Training and Implementation Pilot Initiative. Prior to selection, applications were grouped by IDHS Region so that all 5 regions of Illinois would be represented in the pilot initiative. Given available funding levels, 12 agencies were selected to participate in the initiative and were contacted by e-mail and phone call regarding their selection. From the 12 agencies, 49 behavioral health providers participated in the 2-day SFBT Basics course and 83 additional agency staff participated in 2-hour SFBT overview trainings. Following confirmation of their participation, agencies were randomly assigned to receive either the standard implementation protocol or the standard protocol plus the additional local champion component. The 12 agencies were grouped in matched pairs based on region, type of setting, and characteristics of the population served to promote similar representation in the champion group and control group, with a computerized random number generator used to assign a champion agency and control group agency in each matched pair.

Implementation Protocols

The SFBT pilot initiative included training and implementation support for all participating agencies with additional procedures for champion agencies (see Table 1). All agencies received funds for their providers to receive the 2-day SFBT Basics training, as well as a 2-hour SFBT overview training open to medical providers and support staff. All providers in the initiative also receive the SFBT Treatment Manual (Bavelas et al., 2013) and SFBT Fidelity Instrument (Lehmann & Patton, 2011) to support their implementation of SFBT with fidelity. The Integrated Care team also crafted and sent 6 bi-weekly reminder e-mails to providers with tips and resources for using SFBT in integrated care settings. For the 6 champion agencies, the BHWC provided additional funds for champions to receive two additional days of advanced SFBT courses and biweekly virtual consultation sessions in a group format with the other champions and the trainer. Champions then supported SFBT implementation at their agency by providing monthly consultation groups on SFBT and conducting fidelity review and feedback sessions with each provider at their agency. The champions were also invited to two additional virtual meetings to review the expectations of being a champion and address any questions or concerns regarding implementation.

Table 1. Implementation Protocols at Champion and Non-Champion Sites

Provider at Non-Champion Agency	Provider at Champion Agency	Local Champion
2 days (13 CE hours) of SFBT Basic Training	2 days (13 CE hours) of SFBT Basic Training	2 days (13 CE hours) of SFBT Basic Training
SFBT Treatment Manual	SFBT Treatment Manual	SFBT Treatment Manual
SFBT Fidelity Instrument	SFBT Fidelity Instrument	SFBT Fidelity Instrument
2 virtual check-ins with BHWC SFBT team	2 virtual check-ins with BHWC SFBT team	4 virtual check-ins with BHWC SFBT team
6 biweekly reminder e-mails with tips for using SFBT	6 biweekly reminder e-mails with tips for using SFBT	6 biweekly reminder e-mails with tips for using SFBT
	3 internal consultation meetings with champion	2 days (13 CE hours) of advanced SFBT training
	2 fidelity review feedback sessions with champion	6 biweekly consultation groups with SFBT expert
		Conduct 3 consultation groups with providers
		Review 2 sessions per provider for fidelity review

Evaluation Procedures

To evaluate the initiative and inform future rollout of SFBT training, the pilot initiative included an evaluation component to assess provider and client outcomes from the initiative. The evaluation component consisted of provider surveys, a client evaluation phase, and focus groups with providers and champions. Provider surveys were conducted online via Qualtrics at three time points: pre-training, post-training, and at 4-month follow-up. Multiple reminder e-mails were sent for each survey to maximize the response rate. Out of 49 providers that started the initiative, 45 completed the pre-training survey (92%), 41 completed the post-training survey (84%), and 42 completed the follow-up survey (86%). The survey included scales designed to measure major outcomes of interest:

- Appropriateness of SFBT for Integrated Care Settings
    - Acceptability of Intervention Measure (4 questions)
    - Intervention Appropriateness Measure (4 questions)
    - Feasibility of Intervention Measure (4 questions; Weiner et al., 2017)
- Sustainability of SFBT Implementation in Integrated Care (Malone et al., 2021)
    - Client Outcomes (5 questions)
    - Training and Implementation (5 questions)
- Adoption of SFBT
    - Percent of sessions using SFBT in the last 2 weeks (1 question)

    - Efficiency of services when using SFBT and other approaches (6 questions)
- SFBT Skills
    - SFBT Fidelity Instrument (13 questions; Lehmann & Patton, 2011)
    - Solution Focused Orientation and Skills (10 questions; see Appendix B)

In addition to provider surveys, the program evaluation included a brief client evaluation phase as well as the opportunity for participating providers to take part in focus groups regarding the initiative. By the client evaluation phase, 4 providers out of the original 49 had left their agencies. All 45 remaining providers participated in the client evaluation phase and collectively submitted data on a total of 787 client sessions in May 2024. Providers were instructed to collect data from their clients at the start and end of each session over a 2-week period with every client they saw for a behavioral health session. The Client Evaluation Form (see Appendix C) was limited to four questions on distress, hope, confidence, and goal clarity scored from 1 to 10. After the client section of the form, providers were asked to provide additional background information on prior and expected future sessions with the client, the types of therapy approaches used in the session, and the provider's self-rated fidelity (1 to 10) to SFBT in the session (if they noted using SFBT).

SFBT Training and Implementation Pilot Initiative Participation:

- **12 integrated care agencies**
- **49 providers in 2-day SFBT Training**
- **83 additional staff in 2-hour overviews**
- **6 local champions developed**
- **787 client sessions evaluated**
- **18 focus group participants**

Finally, the evaluation included collection of qualitive data via 7 focus groups conducted with 18 providers from the initiative. Focus groups used a structured interview guide (see Appendix D) asking participants in the initiative about their thoughts on using SFBT in integrated care settings, their experience with the SFBT training they received through the initiative, their perspectives regarding their agencies' implementation of SFBT, and recommendations for future SFBT training and implementation initiatives through BHWC. Additionally, final reports from each agency describing their implementation of SFBT and future sustainability plans were submitted by July 2024.

Data Analysis

The program evaluation used a mixed methods approach combining insights from both quantitative and qualitative data sets to assess the outcomes of the initiative and inform recommendations for future implementation of SFBT in integrated care settings in Illinois. For provider survey data, statistical tests were used to determine if there was change over time (paired samples-tests) or differences between providers at champion and non-

champion agencies (independent samples t-tests). For client evaluation data, more advanced analysis using mixed effects regression models looked at the influence of pre-session scores, use of SFBT, being at a champion agency, and SFBT fidelity on the post-session scores. Finally, qualitative data from focus groups were analyzed using thematic analysis (Braun & Clark, 2021) to identify major themes and the agency final reports were assessed using content analysis to count the frequency of common strategies and experiences with implementation and sustainability that were reported by agencies.

Results

The program evaluation analyzed data from the provider surveys, client evaluation forms, focus group transcripts, and agency final reports to assess the outcomes of the initiative and evaluate the benefits of the champion component. In total, 49 providers at 12 agencies received the 2-day SFBT Basics course, with 94% completing at least one survey.

Sample

Table 2 shows the demographics and background information for 46 providers who took part in the evaluation. The sample was predominantly white, female, and master's level educated, with a fairly even split between social workers and other professions. There were no statistically significant differences between champion and non-champion providers on any of the demographic items except for region. Though the 5 regions were unevenly distributed, there was an even distribution of champion agencies between the Chicagoland region and downstate Illinois due to the matched pairs randomization design.

Provider Surveys

Provider surveys were conducted at three time points: before each provider had received the 2-day Basics training (pre-training), at least two weeks after their 2-day Basics course had been completed (post-training), and between 4 and 5 months after the start of the initiative (follow-up). Table 3 shows the major scales and mean ratings among all providers at the three time points, with paired samples t-tests used to assess for changes over time. On the three measures of perceived fit of SFBT for use in integrated care settings, there were significant improvements in ratings of the acceptability and feasibility of SFBT from pre-training to post-training and from pre-training to follow-up, but no significant difference between post-training and follow-up, suggesting that these improvements were maintained at 4-month follow up. In general, providers tended to agree that SFBT was an acceptable, appropriate, and feasible intervention for use in integrated care setting across all stages of the initiative.

Table 2. Provider Demographics and Background

	All providers (n = 46)		Champion (n = 23)		Control (n = 23)	
	N	Mean/ Pct.	N	Mean/ Pct.	N	Mean/ Pct.
Age	44	42.14	23	43.91	21	40.19
Gender	45		23		22	
Female	36	80.0%	17	73.9%	19	86.4%
Male	9	20.0%	6	26.1%	3	13.6%
Race	41		22		19	
White	29	70.7%	16	72.7%	13	68.4%
Black/African-American	9	22.0%	4	18.2%	5	26.3%
American Indian/Native American/Alaska Native	1	2.4%	1	4.6%	0	0.0%
Asian	1	2.4%	0	0.0%	1	5.3%
Multiple Races	1	2.4%	1	4.6%	0	0.0%
Ethnicity	45		23		22	
Hispanic/Latinx/Latine	4	8.9%	2	8.7%	2	9.1%
Non-Hispanic/Non-Latinx/Non-Latine	41	91.1%	21	91.3%	20	90.9%
Highest Level of Education	45		23		22	
Master's Degree	43	95.6%	23	100%	20	90.9%
Doctoral Degree	2	4.4%	0	0%	2	9.1%
Profession	44		22		22	
Social Work	24	54.6%	10	45.5%	14	63.6%
Counseling	16	36.4%	10	45.5%	6	27.3%
Psychology	2	4.6%	0	0.0%	2	9.1%
Other (Psych. APRN, LMFT)	2	4.6%	2	9.1%	0	0.0%
Setting	46		23		23	
Hospital-Based Clinic	17	37.0%	9	39.1%	8	34.8%
Community-Based Clinic	29	63.0%	14	60.9%	15	65.2%
IDHS Region	46		23		23	
Region 1	19	41.3%	11	47.8%	8	34.7%
Region 2	9	19.6%	0	0.0%	9	39.1%
Region 3	3	6.5%	0	0.0%	3	13.0%
Region 4	10	21.7%	7	30.4%	3	13.0%
Region 5	5	10.9%	5	21.7%	0	0.0%

Note: Champion and Control groups did not differ significantly in any category except IDHS Region which was influenced by the clustering of providers in agencies during matched pairs cluster randomization.

Table 3. Provider Surveys – Implementation Outcomes

	Pre-Training	Post-Training	Follow-Up
Perceived Fit of SFBT			
Acceptability	4.12	**4.39**	**4.45**
Appropriateness	4.27	4.35	4.43
Feasibility	4.01	**4.21**	**4.30**
Adoption of SFBT			
% of sessions using SFBT	32.7%	40.9%	**57.9%***
Clinical Sustainability			
Implementation and Training	--	5.49	5.46
Outcomes and Effectiveness	--	6.05	6.05
Proficiency in SFBT			
Fidelity	4.30	**4.80**	**5.19***
Orientation and Skills	5.85	**7.20**	**7.47**

Bold values show statistically significant improvement compared to pre-training
***Statistically significant improvement from post-training to follow-up

Overall, there was increased adoption of SFBT over the course of the pilot initiative. By 4-month follow-up, providers reported using SFBT in approximately 58% of their sessions on average, compared to 33% of sessions reported at pre-training and 41% of sessions at post-training. Ratings of client outcomes and implementation and training remained stable across the implementation phase, though the ratings reflected generally favorable opinions of effectiveness and implementation on the 1 to 7 scale used in the sustainability measure. Finally, proficiency in SFBT improved throughout the initiative, with improvements in fidelity across each survey and SFBT orientation and skills improving from pre-training to post-training.

Table 4 shows the mean ratings from the survey data with comparison between providers at champion agencies and those in the control group. Again, the perceived fit items on the acceptability, appropriateness, and feasibility of SFBT for integrated care showed high ratings overall, but there were no significant differences over time or for the champion component. Adoption of SFBT in terms of percentage of sessions using SFBT increased in both champion (46% to 62%) and non-champion (36% to 54%) settings from post-training to follow-up, but the difference between champion and non-champion providers was not significant at follow-up (62% vs. 54%, $p = .394$). Notably, both champion and non-champion agencies ended the implementation phase with providers reporting using SFBT in more than half of their sessions.

Table 4. Provider Surveys – Champion Versus Non-Champion Agencies

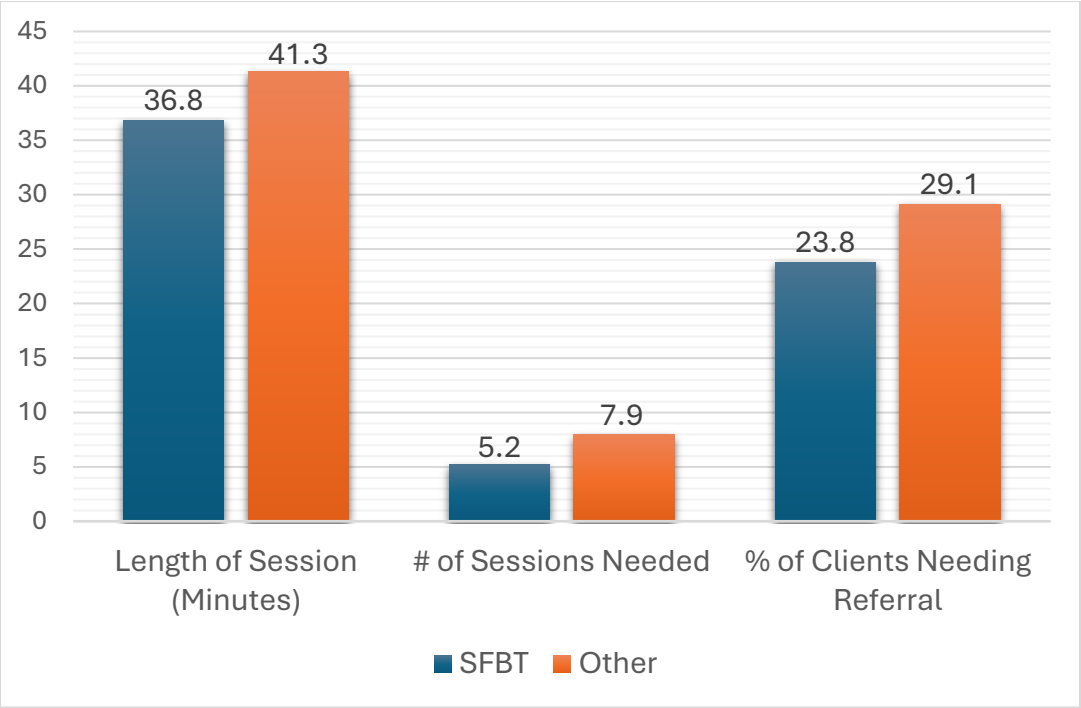
	Post-Training		Follow-Up	
	Champion	**Control**	**Champion**	**Control**
Perceived Fit of SFBT				
Acceptability	4.46	4.32	4.49	4.41
Appropriateness	4.53	4.19	4.55	4.30
Feasibility	4.28	4.15	4.36	4.23
Adoption of SFBT				
% of sessions using SFBT	45.8%	36.3%	61.5%*	54.1%*
Clinical Sustainability				
Implementation and Training	5.76	5.21	**5.91**	4.96
Outcomes and Effectiveness	6.19	5.91	6.23	5.85
Proficiency in SFBT				
Fidelity	4.60	5.00	5.20*	5.18
Orientation and Skills	7.24	7.16	7.72*	7.19

Bold values show statistically significantly better results for the champion component vs. control group
***Statistically significant improvement from post-training to follow-up within the same group

For items related to clinical sustainability and proficiency in SFBT, the results support apparent benefits of the champion component. Regarding sustainability, ratings of the implementation and training in the initiative were significantly higher at follow-up for the champion component (5.91 vs. 4.96). For SFBT proficiency, there was not a significant difference between champion and non-champion agencies for SFBT fidelity or skills, but the champion component did see significant improvement over the course of the initiative in both fidelity and skills while the control group scores remained fairly stable.

Finally, the provider surveys included items related to the efficiency of services when using SFBT or other treatment approaches. In each survey, providers were asked to estimate the length of their sessions, the number of sessions needed to see meaningful change, and the percentage of clients needing referral to more intensive services, both when using SFBT and when using other treatment approaches. Paired samples t-tests were used to determine if providers' ratings of these efficiency items differed based on the type of approach used (see Figure 1). By 4-month follow-up, SFBT exhibited better efficiency than other treatment approaches on all measured items. Providers reported shorter sessions (37 minutes vs. 41 minutes), fewer sessions needed to see meaningful change (5 sessions vs. 8 sessions) and a lower likelihood of needing to refer clients to more intensive services (24% vs. 29%) when using SFBT compared to other treatment approaches.

Figure 2. Efficiency of SFBT vs. Other Treatments



Client Evaluation

To evaluate the client-level outcomes of the initiative, a two-week evaluation phase collected data before and after sessions on clients' self-reported levels of distress, hope, confidence, and goal clarity using 1-to-10 scales. All providers who received SFBT training through the initiative were asked to administer the client evaluation form (see Appendix C) during each of their sessions over the two-week period, regardless of whether they used SFBT in the sessions. In addition to the four pre-post client items, providers were also asked about their use of SFBT, their rating of their SFBT fidelity, the number of prior sessions they had had with the client, and the number of future sessions anticipated. Appendix E shows descriptive statistics for the client evaluation phase, including a breakdown of the descriptive statistics for champion and non-champion providers specifically. All 45 providers who were still at their agencies by the time of the client evaluation phase submitted at least 2 and as many as 64 client evaluation forms, producing a data set representing 787 client sessions.

In terms of client outcomes, there was indication that the services provided at agencies showed within-session benefits for clients. Before-session distress ratings (Mean = 5.25) decreased by about one point in after-session ratings (Mean = 4.13), indicating lower distress by the end of the session. Endorsement of positive indicators showed similar increases by the end of the session, with ratings around 6 at before-session data collection

(Hope = 5.94, Confidence = 6.12, Goal Clarity = 5.81) increasing to around 7 by after-session data collection (Hope = 6.99, Confidence = 7.09, Goal Clarity = 7.13).

To account for the clustering of sessions by provider, the analysis of the client evaluation data used mixed effects regression models specifying provider ID number as a random effect (see Table 5). Four models were run for each of the four client outcome variables to predict the after-session score based on a group of predictors added one at a time in each model. Model 1 used only the before-session rating of each outcome variable to predict the after-session rating, model 2 added the champion component as a predictor of outcomes, and model 3 also included a provider's use of only SFBT in the session as a

Table 5. Mixed Effects Regression Models of Client Outcomes

Model	Dependent Variable							
	Distress		Hope		Confidence		Goal Clarity	
Predictors	B	p	B	p	B	p	B	p
Model 1								
(Constant)	.57		3.15		2.82		3.33	
Pre-Session Rating	.67	**<.001**	.66	**<.001**	.71	**<.001**	.69	**<.001**
Model 2								
(Constant)	.54		3.10		2.87		3.31	
Pre-Session Rating	.67	**<.001**	.66	**<.001**	.72	**<.001**	.69	**<.001**
Champion Agency	.06	.834	.10	.655	-.11	.616	.04	.903
Model 3								
(Constant)	.61		3.06		2.82		3.24	
Pre-Session Rating	.67	**<.001**	.66	**<.001**	.72	**<.001**	.69	**<.001**
Champion Agency	.06	.818	.10	.653	-.11	.606	.04	.900
Used Only SFBT	-.25	**.050**	.13	.231	.16	.130	.23	**.035**
Model 4								
(Constant)	1.28		2.61		2.11		2.41	
Pre-Session Rating	.67	**<.001**	.67	**<.001**	.71	**<.001**	.69	**<.001**
Champion Agency	.16	.544	.16	.465	-.01	.957	.03	.911
Used Only SFBT	.00	.974	-.13	.344	-.08	.553	-.08	.554
SFBT Fidelity	-.12	**.006**	.08	**.036**	.13	**.001**	.16	**<.001**

Note: Provider ID number specified as a random effect in each model to account for variation among individual providers. Statistically significant ($p \leq .05$) predictors are highlighted in **bold**.

predictor. Finally, model 4 included providers self-rating of their fidelity to SFBT in the session as a final predictor of post-session ratings of distress, confidence, hope, and goal clarity.

As seen throughout each model, the pre-session rating was a strong predictor of a client's post-session rating in every domain and independent of any of the predictors added, as expected; clients who rated themselves as more highly distressed were likely to rate as more highly distressed at the end of the session than less distressed clients. Conversely, whether the provider was at a champion agency or not was *not* a significant predictor in any of the models, suggesting that the addition of a champion to support SFBT was not associated with client outcomes. When using SFBT rather than a different intervention was first added in model 3, it was significantly associated with reduced distress and improved goal clarity by the end of the session. However, once SFBT fidelity was added as a predictor in model 4, use of SFBT was no longer a significant predictor for any outcome variable, but SFBT fidelity ratings emerged as a significant predictor of improvements in all four outcomes. This suggests that providers' ratings of better SFBT fidelity were associated with clients' ratings of more positive outcomes at the end of the session. Though model 4 adjusts for both pre-session scores and the decision to use SFBT, the design of the evaluation does not allow for causal inference regarding the direction of effect between fidelity ratings and client outcomes.

The client evaluation data also provided further insights into the anticipated length of services and showed similar trends as the provider surveys for needing fewer sessions when using SFBT. On the client evaluation forms, providers were asked for estimates for the number of times they had already seen a client and the number of future sessions they anticipated with the client. A mixed effects logistic regression model controlling for services that had already exceeded six sessions found that using only SFBT was significantly associated (B = -.58, p = .018) with 44% lower odds of long-term services.

Finally, though champion settings were not significantly more likely to adopt SFBT than non-champion settings, there was indication that providers with hospital-based clinics were particularly inclined to adopt SFBT in a higher proportion of sessions compared to providers at community-based clinics, based on both the provider surveys and client evaluation forms. Though there were no significant differences at pre-training or post-training, at follow-up providers in hospital settings reported higher percentage of sessions using SFBT in the prior 2 weeks (69.7 vs. 50.7) and also had significantly higher odds of reporting SFBT use during sessions of the client evaluation phase (OR: 6.63, p = .005) in a mixed-effects logistic regression.

Focus Groups

Following the client evaluation phase, focus groups were conducted with 18 participants from the initiative, including all 6 local champions and 6 providers each from champion and non-champion agencies who indicated willingness to participate in a follow-up focus group. Major themes emerged from the qualitative analysis of focus group data, including the value of SFBT for integrated care settings, the importance of ongoing support and consultation for using SFBT effectively, and interest and need for further training and support for implementing SFBT in integrated care.

Value of solution-focused approach for effective and efficient services

Participants in the focus groups described various ways in which SFBT was useful for integrated care settings. The brief and solution-focused nature of SFBT in particular aligned with the unique opportunities and constraints of providing behavioral health services in a setting with integrated care and warm handoffs between medical and behavioral providers. Participant #12 explained:

> "We get called into offices like pretty regularly where we really have no idea what's going on in the situation…sometimes we only have 10 minutes to meet with them before the provider needs to get another patient into that office space. So I think that that's been really great to be able to kind of utilize this [SFBT] approach with pretty much anybody. And not necessarily have to know what the problem is before you go in to meet with those patients. So I find that really helpful."

One key element that supported the appropriateness of SFBT for integrated care was improved efficiency of services when using SFBT compared to other approaches, which aligns with the quantitative findings on efficiency of services. Participant #7 expressed the agency-wide benefits of having more efficient behavioral health care using SFBT:

> "We have been able to get our wait list down tremendously, because we are still doing SFBT, and we are also doing the time limited sessions. So, I have been doing SFBT primarily and having 10 sessions for patients. So that has helped us, you know, get patients in and out and they're getting their appointments with us very quickly, using this method."

Similarly, participant #6 noted "it seems like we are getting patients kind of in and out much faster than we were before doing solution-focused brief therapy" and participant #3 quantified the change as a noticeable reduction in visits: "I am surprised… how quick the visits will go and how I'm only seeing patients now 3, 4 times and with other techniques or modalities I have used, you know, I'm using 6, 7, 8 visits." At the far extreme of efficiency, several providers noted that the training they received on SFBT encouraged them to

> ***"I think that this is exactly what we were kind of looking for. Since we are an integrative care setting, I don't think that we were equipped to do longer term therapy…We have been able to get people in and out faster."***
>
> **-Participant #7 (Local Champion)**

treat each session as though it could be the last, with potential benefits even in a single session. For example, participant #4 said “I like the brevity of the sessions. The idea that even just one session could have really good impact for the patient.” Participant #9 added “I think it’s very helpful for those very short appointments and people who don’t come back.”

In addition to efficiency, providers described the value of shifting their focus to strengths and solutions and a more client-driven approach. This shift also reduced some of the pressure and stress on therapists themselves. Participant #4 noted, “I also really appreciated that it gave us an opportunity to ask the patients to elicit what they could do. [At] first, I think I put a lot of pressure on myself to come up with the solutions.” Participant #6, a local champion at her agency, described the benefits of the more positive focus for her whole team:

> “For the most part, I think we've all been really happy and just feel like it's also stopped us from being kind of down in the depths with patients and being able to just kind of have the conversation be much more hopeful and positive for the future.”

Importance of ongoing support and consultation

Though focus group participants generally expressed a favorable opinion of the appropriateness of SFBT for brief intervention in integrated care settings, there was also a common theme expressed regarding a “learning curve” for using SFBT skills and adjusting to a solution-focused mindset. This observation aligned with a broader theme of the importance of ongoing support and consultation to promote the effective and continuing use of SFBT. Notably, the feedback regarding the helpfulness of ongoing support appeared in all three focus groups even though the forms of ongoing support differed for each group. For providers in the non-champion group, the biweekly reminder and tip e-mails were the primary form of ongoing support received, and respondents identified them as helpful. Participant #2 stated “I thought those were helpful, just of kind of like reminders, every couple of weeks to get one of those and be like, oh yes, I can incorporate that today.” For providers in the champion group, the local champion was their source of ongoing support through monthly internal consultation groups and serving as an agency contact person for SFBT. Participants valued this consultation, as well as having a point person at the agency to promote the use of SFBT. Participant #9 shared:

> One of the most helpful things was the consultation, but also her enthusiasm. We had a really good champion. She's very excited about it, and she's very good at like talking it up so like I think we had a very good champion for that, because not only is she good at doing that for our behavior health team, but also for outside of our team, like really selling it.

In addition to the formal monthly consultations, participants at champion agencies also appreciated having someone to go to for questions and support. Participant #12 stated “I would just say the most helpful was just knowing that there’s an additional person with

additional training that I could reach out to [who] was available as needed." Participant #8 went so far as to describe this extra support as "necessary": "I think the champion component was necessary/helpful to have an on-site provider able to answer questions/give advice."

Finally, the champions themselves received additional advanced training and biweekly consultation groups with the SFBT expert trainer, in addition to being expected to run the internal consultation groups and conduct fidelity reviews. Participant #5 noted the value of these elements, stating "The consultation groups were super helpful and the fidelity forms were super helpful, so, those being the most helpful things." Champions also noted how they also appreciated the peer learning aspect of doing the external consultation groups with the other champions in the initiative. Participant #7 shared, "I think that I actually learned a lot from the group that we had, like, knowing what other agencies where kind of doing…It was nice to have this co-work group together."

> ***"I think having that kind of ongoing additional support for the agency and the providers…makes a world of difference…I think I would have fizzled out on SFBT had my agency only gotten the 2-day training and then nothing else."***
>
> **-Participant #6 (Local Champion)**

Importantly, several champions noted how the implementation protocols and enhanced champion component made a difference for implementation and sustainability compared to other approaches they had been trained in. Referring to both the external consultation sessions with the expert training and the biweekly reminder e-mails sent to all providers, Participant #13 noted how these aspects were helpful in "being able to kind of just keep it on the top of my mind…I think that was something that's different than other trainings we've done where you get the initial big training…but then you forget about it." Similarly, participant #6 summarized the difference made by ongoing consultation and support:

> I think, like, many times I take a training, and then it fizzles out because I have too many questions. It's not making sense. I feel too awkward in the session. And then I eventually just kind of give up. And so I think that champion component really helps with sustainability to keep trying and keep working out problems and having that extra knowledge.

Interest and need for further training and support

Though participants expressed that the training and consultation they received was helpful, there was also a common refrain of wishing for even more training and consultation, or expanding the training and consultation to more staff than received it during the initiative. As noted previously, participants identified a learning curve involved in switching to a solution-focused mindset and process, which left some participants

wanting more training to become confident in their use of SFBT. Participant #17 described wishing they had received the advanced training given to champions:

> My biggest, I guess, difficulty was that [I didn't receive] the second round, which I think would have furthered my knowledge and actual implementation of it. The first two days is pretty basic in philosophy and knowledge and some implementation. But I just feel like I needed more.

Participants also discussed wanting more training for non-behavioral health staff beyond the two-hour overview training. Participant #1 stated, "I wish the medical side of us and the BH side of us we could all be in this training together when getting this training, because a lot of, you know, our medical providers are very interested in this." Not surprisingly, there was also interest in more ongoing consultation and support across all three focus groups. For non-champion providers who received only the biweekly e-mails, there was a desire for additional instruction and "refreshers." Participant #2 supported the idea of "having some, you know, refreshers, maybe implementation videos along the way" in addition to the SFBT manual and reminders. For providers at champion agencies who did receive the monthly internal consultation sessions specified in the enhanced implementation protocol, there was a desire for more frequent consultation groups:

> One thing I would recommend was that we did that on a more consistent basis. We just had a couple of those meetings which I would have liked to have done, maybe once a week during this initial time period. (Participant #12)

The interest in more training and support was significant enough that some agencies took steps to add additional support on their own. Importantly, at least one non-champion agency that was not tasked with creating a point person for implementation support noted that this occurred informally. Participant #4 stated, "I don't know about other agencies, but even though we did not have a champion assigned, I feel like there was almost accidentally kind of a champion kind of coming up…I sort of took it on myself." Finally, among the local champions, who received the greatest level of training and support, there was still feedback that more would be helpful. Participant #5 whimsically noted "I just wish I could carry [the trainer] around in my pocket, honestly." Regarding consultations, Participant #6 added, "I would always advocate, for you know, monthly consultations for a little longer. I mean, I don't think any of us would turn that away if it was offered to us." Additionally, Participant #5 expressed an interest in expanding the external consultation groups with an SFBT expert to more providers than just the champion: "potentially more than just champions getting [expert] consultation, 'cause I think us providing the consultation while

> ***"Some [of our staff] have had the 2 days [training], some have just had the 2 hour, some have had none at all and so to really be able to see where this could go with the department, I think It would be most beneficial to have the entire staff trained.***
>
> **-Participant #8 (Local Champion)**

we're learning was good, but it could have been beneficial for some of my other staff to have that with [the expert trainer]."

Overall, the focus group participants recommended further SFBT training and implementation for integrated care agencies in Illinois, with recommendations for ongoing consultation and support as a key factor in a successful implementation initiative.

Agency Reports

After the end of the evaluation phase of the pilot initiative, agencies were asked to submit brief final reports regarding their participation in the initiative. Key areas for the final reports included describing their agency's implementation of SFBT during the initiative as well as plans for sustaining use of SFBT after the initiative and retaining the staff trained during the initiative. Content analysis identified common themes among the agency final reports, with the report's first two authors conducting the content analysis. Table 6 shows notable themes from the reports along with counts of how many total agencies, champion agencies, and non-champion agencies mentioned that theme in their report. Regarding use of SFBT, the final reports echoed the focus group feedback that SFBT was experienced as well-suited for brief behavioral health services in integrated care settings (7 agencies), effective for improving patient outcomes (4 agencies), and facilitated more efficient services that allowed agencies to serve more patients (3 agencies). Notably, one agency specifically stated that using SFBT was associated with shorter sessions and fewer sessions, which enabled more patients to receive services using the same level of behavioral health staffing. In contrast, 2 out of the 12 agencies noted that they felt that certain types of patients were not a good fit for SFBT and that they used other treatment approaches with those clients. Situations when other approaches were chosen included clients with substance use, suicide ideation, homicide ideation, or clients that were difficult to redirect to a solution focus.

In terms of strategies for implementing SFBT in their agency, 11 total agencies (including 5 non-champion agencies) stated that their providers received regular meetings and/or consultation to help support their use of SFBT. This poses a potential limitation for the evaluation of the pilot initiative, since internal consultation groups were a key aspect of the enhanced champion component and nearly all of the non-champion agencies chose to provide similar support for staff even though this was not specified in the baseline implementation protocol. However, the fact that nearly every agency chose to provide meetings and consultation supports the value of this implementation approach and again echoes the focus group feedback regarding the importance of ongoing consultation and support. Additionally, 7 agencies described efforts to change processes or shift the agency's culture to support the implementation of SFBT by providers. Specific strategies included creating solution-focused template language for documentation, internal review

Table 6. Common Themes from Agency Final Reports

Theme	Agencies Reporting Theme		
	Non-Champion	Champion	Total
IMPLEMENTATION			
SFBT was well-suited for agency's use of brief intervention in integrated care settings	4	3	7
Agency decided to offer treatments other than SFBT to certain types of patients	1	1	2
SFBT was effective for improving patient outcomes	2	2	4
SFBT facilitated more efficient services that allowed agency to serve more patients	2	1	3
Agency providers received regular meetings and consultation to support use of SFBT	5	6	11
Agency faced challenges in implementing SFBT due to staffing issues and turnover	2	2	4
Agency undertook efforts to incorporate SFBT into existing agency processes and culture	2	5	7
SUSTAINABILITY			
Agency anticipates continued or expanded use of SFBT by their providers	4	5	9
Agency plans to continue regular meetings and consultation on SFBT after the pilot initiative	3	6	9
Agency plans to conduct additional SFBT training for current and new staff	6	6	12
The alignment between SFBT and the agency's use of integrated care supports sustainability	1	1	2
RETENTION			
Implementing SFBT supports retention at the agency by increasing staff satisfaction	2	3	5

of SFBT implementation efforts, consultation on how to integrate SFBT into a Primary Care Behavioral Health (PCBH) integrated care model, and even updating departmental policies to require the use of SFBT. For these efforts to promote a culture shift toward SFBT, having a local champion to serve as a point person may have been beneficial as evidenced by 5 champion agencies noting these themes compared to only 2 non-champion agencies. Finally, four agencies noted challenges with implementation related to staffing issues and turnover, such as staff leaving during the initiative (2 agencies) or provider availability limiting how many staff at the agency could go through the training.

Regarding sustainability of SFBT following the end of evaluation phase of the pilot initiative, agencies reported in their final reports plans to continue using SFBT and continued staff training on SFBT. In fact, all 12 agencies indicated in their final report that they planned to have future SFBT training for new staff or additional training for current staff. Additionally, 9 agencies—including all 6 champion agencies—reported plans to continue to have regular meetings and consultation for their providers on SFBT, often provided by the local champion who received advanced training during the pilot initiative. Alongside continued training and consultation, most agencies noted in their reports that they expected continued or expanded adoption of SFBT by their providers, with two agencies noting that sustained use of SFBT was more likely due to the alignment between SFBT and their agency's integrated care model. Finally, agencies were asked to include in their final reports their plans for retaining the SFBT knowledge developed during the initiative through staff retention efforts. Alongside general retention measures related to pay and work-life balance, 5 agencies (3 champion) described how implementing SFBT supported staff retention by promoting a "heightened sense of empowerment and accomplishment" from applying their SFBT training with clients.

Sustainability and Retention Strategies

- **All 12 agencies plan future SFBT training for their staff**
- **All 6 champion agencies plan to continue regular consultation on SFBT**
- **Agencies plan to retain the staff trained in SFBT through competitive pay, flexible scheduling, and other work-life balance measures**
- **5 agencies report that using SFBT supports staff retention through increased staff satisfaction**

Summary of Findings

The initial pilot initiative of the BHWC SFBT Training and Implementation Initiative evaluated the outcomes and provider experiences with using SFBT in integrated care and further evaluated the addition of a local champion component to SFBT implementation. Findings support the appropriateness of SFBT for integrated care settings, with benefits for more efficient services that may extend the reach of the current behavioral health workforce in meeting the needs of Illinois residents. The champion component showed some indication of potential benefits for implementation and fidelity compared to the baseline protocol. However, in many areas there were not significant differences between champion and non-champion agencies. The small sample size may have limited the evaluation's power to detect differences between the groups. Further evaluation is needed

regarding the long-term impacts of local champions and the cost-effectiveness of developing these local experts. Key findings of the pilot initiative evaluation include:

- At four-month follow-up, using SFBT was associated with shorter sessions, fewer sessions needed, and a lower likelihood of needing referral to more intensive treatment compared to other treatment approaches
- Using SFBT was associated with greater single-session improvements in client reported distress and goal clarity compared to other treatment approaches
- Providers' self-rated fidelity to SFBT was significantly associated with better client-reported single-session outcomes for distress, hope, confidence, and goal clarity
- Ratings of SFBT fidelity and skills increased following two-day intensive SFBT training for all providers.
- Providers in the champion component showed additional increases in SFBT fidelity and skills over the course of the implementation period that were not seen for providers at non-champion agencies.
- Providers in champion agencies gave significantly higher ratings for implementation and training compared to providers at non-champion agencies.
- Hospital-based clinics had higher adoption of SFBT in the client evaluation phase and at follow-up than community-based clinics
- Surveys, focus groups and agency final reports indicate that SFBT is viewed as a feasible, effective, and efficient approach for brief intervention in integrated care
- Focus group participants emphasized the importance of ongoing training and consultation to support adoption and fidelity to SFBT techniques
- Nearly every agency in the initiative reported providing regular consultation for staff on the use of SFBT in integrated care and all agencies planned to pursue future staff training on SFBT
- Approximately half of agencies indicated that using SFBT supported staff retention through increased provider satisfaction

Given the promising findings of the pilot initiative, further rollout of SFBT Training and Implementation is recommended for integrated care settings in Illinois, with further evaluation warranted regarding sustainable and cost-effective approaches for SFBT implementation in integrated care.

Discussion and Implications

Integrated care that co-locates and coordinates medical and behavioral health services offers a key avenue for increasing access to timely and effective behavioral health care for the residents of Illinois (Hostutler et al., 2023). Providing immediate and convenient access to mental health support as soon as it is identified in a primary care appointment

decreases complications and delays in accessing the behavioral health system, and effective brief intervention may allow many challenges to be addressed before they rise to the level of needing more intensive or long-term behavioral health services (Hostutler et al., 2023; Vogel et al., 2017). Thus, it is important to identify and implement effective brief interventions in integrated care and to train behavioral health providers to provide brief interventions effectively.

SFBT is an evidence-based practice that supports a strengths-based and brief approach to behavioral health therapy (Lee & Eads, 2024; Kim et al., 2019). Consistent with prior literature (Zhang et al., 2018), this pilot evaluation found that SFBT was helpful for clients in a short amount of time, with benefits in even a single session for reducing distress and increasing goal clarity. Providers and agencies also consistently reported that SFBT facilitated more efficient services than other treatment approaches that they used. Focus group feedback aligned with the client evaluation phase findings that meaningful benefits could be seen in a single SFBT session, with several participants endorsing the viewpoint of treating every SFBT session as though it could be the last session the client needed.

Given the apparent appropriateness and feasibility of SFBT for enhancing the efficiency of behavioral health services in integrated care, it is important to consider how best to approach training and implementation of SFBT for integrated care settings in Illinois. Evidence-based interventions such as SFBT are most effective when providers consistently use them and use them with fidelity (Frank et al., 2020). In fact, the client evaluation phase of the pilot initiative clearly showed an association between using SFBT and single-session improvements in distress and goal clarity, with further findings showing that fidelity to SFBT was an important factor in seeing improvement in all areas that were assessed. Importantly, the pilot initiative evaluation showed improvement in both adoption and fidelity over the course of the implementation phase.

The evaluation of the champion component found limited evidence of significant benefits compared to the baseline protocol. In the provider surveys, implementation and training were rated higher by the end of the pilot initiative at champion agencies, and providers at champion agencies showed ongoing improvement in SFBT fidelity skills that were not evident among non-champion providers. However, there did not appear to be differences between champion and non-champion agencies in terms of adoption of SFBT or client outcomes. The assessment of the benefits of local champion was limited by a small sample size and the indication that some agencies in the control group used several of the implementation strategies assigned to champion agencies, such as having a local SFBT point person and offering internal consultation on SFBT for their providers. The qualitative feedback supported the helpfulness of the ongoing support and consultation provided by champions and highlighted that training alone would not promote sustainability.

With the evidence supporting the benefits of SFBT implementation for integrated care settings, the evaluation indicates the following implications for supporting the behavioral health workforce in Illinois

- SFBT training for integrated care settings is a cost-effective way to expand the reach of the current behavioral health workforce through increased efficiency of services.
- For an average investment of $2,418 per provider, the pilot initiative showed that providers using SFBT could help clients see meaningful change in an average of 2.75 fewer sessions.
- Developing local champions cost on average $1,170 more per provider than ($3,039 total) and was associated with a .95 point increase on the training and implementation scale of a sustainability measure.
- Continued evaluation should investigate the potential long-term benefits for sustainability at agencies that developed local champions during the pilot initiative.
- Focus groups and agency final reports suggested that SFBT may have benefits for reducing provider burnout and promoting retention that should be explored further in future data collection evaluating the SFBT Initiative.
- Providers indicated that ongoing consultation and support is key to implementing and sustaining SFBT, and further evaluation should determine the most cost-effective way to provide this support.
- Learning collaboratives have shown benefits for providing ongoing support compared to one-time trainings (Gotham et al., 2023), and future rounds of the SFBT Training and Implementation Initiative should evaluate the use of a solution-focused learning collaborative to promote adoption, fidelity, and sustainability of SFBT in integrated care.
- The improvements in efficiency through the use of SFBT contributed to all 12 agencies in the pilot phase of the initiative reporting plans to pursue future SFBT training for their staff

Given the benefits seen in this evaluation for increased efficiency of services and the continued interest among integrated care agencies in SFBT training, further rollout of SFBT training and implementation is recommended and should include further evaluation of the sustainability of local champions and the cost-effectiveness of a learning collaborative.

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Appendices

Appendix A

BHWC SFBT Training and Implementation Initiative
Recruitment and Evaluation Procedures

Request for Proposals and Agency Selection

In August 2023, a Request for Proposals (RFP) was distributed to integrated care agencies across all regions of Illinois. E-mails were sent to all integrated care sites that had been previously identified as part of the BHWC integrated care survey as well as through the contact lists of the Illinois Hospital Association and the Illinois Primary Health Care Association. Two information sessions were held in September and October 2023 to answer questions regarding the application process. The Integrated Care team created a scoring document to rate each application on adherence to integrated care principles, capacity to reach high-need populations, implementation and sustainability plans, and demonstrated capacity to complete implementation procedures and the champion component as described in the RFP. Each application was independently scored by two reviewers before proceeding to the full Integrated Care team for selection decisions. In rare cases when a team member had a prior relationship with an agency, that member recused themselves from both scoring and the discussion of the application during the selection process. Of the 18 applications submitted, 12 were selected to receive funding through the initiative.

Evaluation Procedures

To evaluate the initiative and inform potential future rollout of SFBT training, the pilot initiative included an evaluation component to assess provider and client outcomes from the initiative. Prior to the start of the initiative, the evaluation procedures were submitted to the Institutional Review Board of the University of Illinois Chicago and was determined not to be human subjects research as a non-research program evaluation (STUDY 2023-0911). The evaluation component consisted of provider surveys, a client evaluation phase, and focus groups with providers and champions.

The provider surveys included information about the program evaluation as well as questions on the demographic and background information of providers. The surveys were designed to capture implementation-level outcomes related to the efforts to implement SFBT in integrated care settings and included a combination of established instruments and items and scales crafted specifically for the evaluation. For provider's perceptions of the fit of SFBT for behavioral health in integrated care, the survey included three related measures of perceived fit: the Acceptability of Intervention Measure (AIM), Intervention

Appropriateness Measure (IAM), and the Feasibility of Intervention Measure (FIM; Weiner et al., 2017). Each measure consists of 4 items rated on a five-point scale from completely disagree to completely agree. The measures have been subject to prior psychometric testing and showed reliability and substantive and discriminant validity (Werner et al., 2017). In the present sample, the AIM, IAM, and FIM displayed strong internal consistency with Cronbach's α of .880, .963, and .875, respectively. In addition to measuring perceived fit, the survey sought to capture provider's views on the sustainability of SFBT implementation in their agencies via the Clinical Sustainability Tool (CSAT; Malone et al., 2021). The full CSAT consists of 35 items rated on a seven-point scale from 1 "To little or no extent" to 7 "To a very great extent" and has established good psychometric properties in prior research (Malone et al., 2021). For the purposes of the evaluation, two subscales of five items each were incorporated into the provider surveys: the implementation/training subscale and the outcomes/effectiveness subscale. Both subscales showed strong internal consistency in this evaluation with Cronbach's α of .841 for implementation and .900 for outcomes. The final formal measure included in the provider surveys was the Solution-Focused Fidelity Instrument, a measure of 13 items capturing use of different SFBT techniques in a session from 1 "Not at all" to 7 "Yes, clearly and specifically", which has shown good reliability in prior research (Lehmann & Patton, 2011). The fidelity measure also showed very strong internal consistency in the present sample with a Cronbach's α of .936.

In addition to formal measures, a number of items were added to the survey to help capture expected changes from before training began to the end of the implementation phase of the pilot initiative. First, a set of items on adoption of SFBT asked providers to report the percentage of sessions in the last 2 weeks in which they used SFBT. Follow-up items asked providers to self-report the length of sessions in minutes, the number of sessions it takes for meaningful change occur, and the percentage of clients needing to be referred to more intensive levels of care, both when using SFBT and when using other approaches besides SFBT. Finally, it was important to the evaluation to be able to measure changes in SFBT skills and alignment with the orientation of SFBT from before training to later points in the initiative. As the SFBT Fidelity measure questions only applied if a provider was already using SFBT to some extent, the Integrated Care Team developed a 10-item homegrown measure of solution-focused orientation and skills (see Appendix B) to assess changes in SFBT proficiency even if a provider had no prior experience with the model. To fit the style of scaling questions used in SFBT (Lee et al., 2022) each item was scored on a 10-point scale ranging from 1 "do not agree at all" to 10 "completely agree." Though the measure has not been subjected to full psychometric analysis, it showed acceptable internal consistency in the present sample (Cronbach's α = .849).

Provider surveys were conducted online via Qualtrics at three time points: pre-training, post-training, and at 4-month follow-up. The link for pre-training surveys was sent to all providers identified by their agencies as participating in the initiative at least two weeks prior to the start of their scheduled 2-day SFBT Basics training, which was conducted via three cohorts from January to February 2024. The post-training link was distributed to providers 2 weeks after the last day of their SFBT Basics training. The follow-up link was distributed to all providers after the client evaluation phase ended, which was in late May 2024, 4 months after the first SFBT training began. Since the implementation phase did not begin until after the training had been completed, the CSAT subscale items were only included on the post-training and follow-up surveys. All other scales and items were asked in all three surveys.

In addition to provider surveys, the program evaluation included a brief client evaluation phase as well as the opportunity for participating providers to take part in focus groups regarding the initiative. To make the initiative as feasible and provider-friendly as possible, two decisions were made regarding the implementation and evaluation of the initiative. First, providers were encouraged but not required to use SFBT in their behavioral health sessions and were free to combine SFBT techniques with other approaches they already used. Second, the client evaluation component was limited to a two-week period at the end of the implementation phase rather than requiring data collection throughout the initiative. In early May 2024, the BHWC team met with providers, champions, and representatives from each agency in the initiative to go over expectations and procedures for the 2-week client evaluation. Each provider was assigned a Provider ID and Agency ID number for use during the evaluation and received PDF and Google form versions of the Client Evaluation Form (see Appendix C). To provide a provider- and client-friendly experience, the client items were limited to four questions asked before and after each session. The items used the same 1-to-10 format as the SFBT scaling questions that providers received training on and largely focused on the strength- and future-oriented mechanisms associated with effective SFBT (Franklin et al., 2017). The four items each represented separate dimensions of distress, hope, confidence, and goal clarity. After the client section of the form, providers were asked to provide additional background information on prior and expected future sessions with the client, the types of therapy approaches used in the session, and the provider's self-rated fidelity (1 to 10) to SFBT in the session (if they noted using SFBT). As with the rest of the initiative, providers were not required to use SFBT and were asked to complete the client evaluation form in every behavioral health session during the two-week period regardless of whether they used SFBT or not. By the client evaluation phase, 4 providers out of the original 49 had left their agencies. All 45 remaining providers participated in the client evaluation phase and collectively submitted data on a total of 787 client sessions in May 2024.

Finally, the evaluation included collection of qualitive data via focus groups at the end of the initiative and the submission of final reports by each agency describing their implementation of SFBT and future sustainability plans. Focus groups used a structured interview guide (see Appendix D) asking participants about their experiences with the initiative. Additionally, providers and local champions at champion agencies were asked for their insights about receiving the champion component or serving as a local champion, as applicable. Separate focus groups were conducted with providers at non-champion agencies, providers at champion agencies, and for local champions and took place in late May and early June 2024. Final reports were also requested from each agency outlining their implementation of SFBT and plans for sustaining SFBT at their agency.

Data Analysis

The program evaluation used a mixed methods approach to integrate the findings from quantitative and qualitative data sources to inform conclusions regarding the outcomes of the initiative and recommendations for future SFBT implementation in integrated care settings in Illinois. Provider surveys were collected at three time points and included participants at both champion and non-champion (control group) agencies. Scale scores for the survey instruments were constructed by taking the average of non-missing scores on scale items so that a very small amount of missing data on scale items was addressed through participant row mean imputation. Changes over time on survey items and scales were assessed through paired samples t-tests comparing the average scores of the different surveys. Differences between champion and non-champion providers on survey scales were assessed through independent samples t-tests at each time point. For items related to a provider's self-report of the efficiency of services when using SFBT and other approaches, paired samples t-tests were used at each time point to assess differences reported by providers based on which approach they used.

The client evaluation phase produced pre- and post-session data clustered by providers. To account for individual variation among providers, mixed effects maximum likelihood regression models were used with provider ID specified as a random effect. Separate analyses were run for each of the 4 variables assessed on the client evaluation form. In each model, the post-session score for the variable was specified as the dependent variable, with four models sequentially adding new predictors in each model. In Model 1, only the pre-session score for the variable was included as a predictor. Models 2 through 4 added receiving the champion component, using SFBT only, and self-rated level of SFBT fidelity, respectively. Additional models specified anticipated length of services and likelihood of using SFBT as dependent variables. On client evaluation forms, providers were asked to give estimates for the number of times they had already seen a client and the number of additional sessions they anticipated with the client; a variable for long-term services was created, defined as five or more additional sessions. A mixed-effects logistic

regression model was used to assess the likelihood of long-term services based on receiving the champion component and using SFBT only, with a control variable representing clients who had already received long-term services and provider ID again specified as a random effect. For use of SFBT, another mixed-effects logistic regression model was used with setting type (hospital or clinic) as the independent variable and provider ID as a random effect. For all quantitative analyses, an alpha of .05 was used to assess the statistical significance of each test.

The focus groups and agency final reports were analyzed using qualitative methods. Two members of the evaluation team reviewed and coded transcripts from the three types of focus groups (non-champion provider, champion provider, and local champion). Thematic analysis (Braun & Clark, 2021) was used to develop common themes among the focus groups, supported by direct quotes from participants. Agency final reports were assessed using content analysis to identify common elements in sustainability and retention plans following the initiative. The coding team for the qualitative analysis consisted of the first four authors of the report and included a university faculty member with SFBT expertise, an initiative coordinator with substantial work experience providing SFBT in integrated care settings, and research associates with qualitative analysis expertise and experience. Following the separate analysis of each component, the quantitative and qualitative findings were then compared to inform conclusions regarding the appropriateness of SFBT for integrated care, the outcomes of the implementation initiative, and recommended future directions for further support of effective brief interventions in integrated care to increase the capacity of the behavioral health system through accessible and efficient services.

Appendix B

Solution-Focused Orientation and Skills Items

For the following items, please rate your agreement with each statement from 1 (do not agree at all) to 10 (completely agree)

1. I feel confident in using SFBT in behavioral health sessions with clients
2. I have the knowledge I need to use SFBT effectively with clients
3. I need to have a thorough understanding of the problem in order to help my clients change
4. I can help clients envision their desired future even if I don't fully understand how their problem started
5. I feel I am being neglectful if I do not complete a thorough assessment of the history of the problem.
6. I truly believe that my clients are capable of changing their lives on their own
7. My client probably already started making changes in their life before coming to their first session with me
8. I am able to use SFBT techniques and questions to help my clients change
9. When clients leave my sessions, they have a better understanding of the future they would like to have
10. I know how to help clients identify the strengths and resources they already have

Note: Items 3 and 5 should be reverse coded for higher scores to represent greater alignment with SFBT orientation and skills.

Appendix C

Solution-Focused Brief Therapy (SFBT) Training and Implementation Initiative
Client Evaluation Form

Description

As part of your agency's participation in the Solution-Focused Brief Therapy (SFBT) Training and Implementation Initiative, you are being asked to collect data in each behavioral health session from **5/13/2024** to **5/24/2024**. It is important that your clients complete these questions at the start of the session and again at the end of the session. Please complete the provider section after the end of the session.

Before Session (Client)

1) Please rate your current level of mental and emotional distress from 1 to 10, where 1 is least distress and 10 is most distress: _____

2) On a scale from a 1 to 10, where 1 is least hopeful and 10 is most hopeful, how hopeful do you currently feel? _____

3) On a scale from 1 to 10, where 1 is least confident and 10 is most confident, how confident do you currently feel that you can make positive changes in your life? _____

4) On a scale from 1 to 10, where 1 is least clear and 10 is most clear, how clear of a picture do you currently have of the next steps you need to take to achieve your goals for yourself? _____

After Session (Client)

1) Please rate your current level of mental and emotional distress from 1 to 10, where 1 is least distress and 10 is most distress _____

2) On a scale from a 1 to 10, where 1 is least hopeful and 10 is most hopeful, how hopeful do you currently feel? _____

3) On a scale from 1 to 10, where 1 is least confident and 10 is most confident, how confident do you currently feel that you can make positive changes in your life? _____

4) On a scale from 1 to 10, where 1 is least clear and 10 is most clear, how clear of a picture do you currently have of the next steps you need to take to achieve your goals for yourself? _____

Provider Section

1. Agency ID: _____
2. Provider ID: _____
3. Date of Session: _____
4. Approximate Start Time of Session: _____
5. Have you seen this client before? (circle one) Yes No
    a. If yes, how many times have you seen this client before this session? ____
6. Do you plan to meet with this client again? (circle one) Yes No
    a. If yes, what is your best guess of how many additional sessions you will have with this client? _____
7. Did you use SFBT with this client? (circle one) Yes No
8. What other treatment approach(es) did you use?_____
9. If you used SFBT, please rate your fidelity to SFBT (how well you followed the philosophy and techniques of SFBT that you were trained on) in this session on a scale from 1 to 10, where 1 is very low fidelity to SFBT and 10 is complete fidelity to SFBT: _____

Appendix D

Focus Group Interview Guide

Control Group Providers

1. Please share your thoughts on using solution-focused brief therapy (SFBT) in integrated care settings.
    a. What has your experience been like using SFBT with your clients?
    b. What have been the pros and cons of using SFBT?
    c. How does SFBT compare to other approaches you have used?
2. Please share your thoughts on the SFBT training you received through the BHWC SFBT initiative.
    a. What was your experience like with the training?
    b. What was most helpful about the training?
    c. What changes would you recommend that would have improved your experience with training?
3. Please share your thoughts on the implementation of SFBT at your agency through the BHWC SFBT initiative.
    a. What was your experience like with implementing SFBT at your agency?
    b. What was most helpful to you in implementing SFBT and using it with your clients?
    c. What kinds of support did you receive at your agency to help you use SFBT effectively?
    d. What changes would you recommend that would have helped you better implement and use SFBT effectively with your clients?
4. Please share your recommendations for the next phase of the BHWC integrated care initiative.
    a. Would you recommend expanding the SFBT initiative to additional integrated care agencies? Why or why not?
    b. What parts of the SFBT training and implementation would you want to keep or change in the next phase of the initiative?
    c. What other trainings or initiatives do you think the BHWC should support to improve behavioral health services in integrated care settings?
5. What else would you like to share that has not already been discussed?

Focus Group Interview Guide

Local Champion Providers

1. Please share your thoughts on using solution-focused brief therapy (SFBT) in integrated care settings.
    a. What has your experience been like using SFBT with your clients?
    b. What have been the pros and cons of using SFBT?
    c. How does SFBT compare to other approaches you have used?
2. Please share your thoughts on the SFBT training you received through the BHWC SFBT initiative.
    a. What was your experience like with the training?
    b. What was most helpful about the training?
    c. What changes would you recommend that would have improved your experience with training?
3. Please share your thoughts on the implementation of SFBT at your agency through the BHWC SFBT initiative.
    a. What was your experience like with implementing SFBT at your agency?
    b. What was most helpful to you in implementing SFBT and using it with your clients?
    c. What changes would you recommend that would have helped you better implement and use SFBT effectively with your clients?
4. Please share your experience with the "local champion" component of your agency's SFBT implementation plan.
    a. What sorts of contacts or support did you receive from the local SFBT champion at your agency?
    b. What was most helpful about having a local champion?
    c. What changes would you recommend that would have improved the local champion component of your agency's implementation plan?
    d. Other than the local champion, what kinds of support did you receive at your agency to help you use SFBT effectively?
5. Please share your recommendations for the next phase of the BHWC integrated care initiative.
    a. Would you recommend expanding the SFBT initiative to additional integrated care agencies? Why or why not?
    b. Would you recommend that future agencies in a SFBT initiative receive the local champion component versus staff training only? Please explain.
    c. What parts of the SFBT training and implementation would you want to keep or change in the next phase of the initiative?
    d. What other trainings or initiatives do you think the BHWC should support to improve behavioral health services in integrated care settings?
6. What else would you like to share that has not already been discussed?

Focus Group Interview Guide

Local Champions

1. Please share your thoughts on using solution-focused brief therapy (SFBT) in integrated care settings.
    a. What has your agency's experience been like using SFBT with your clients?
    b. What have been the pros and cons of using SFBT?
    c. How does SFBT compare to other approaches you have used?
2. Please share your thoughts on the basic SFBT training you received through the BHWC SFBT initiative.
    a. What was your experience like with the training?
    b. What was most helpful about the training?
    c. What changes would you recommend that would have improved your experience with training?
3. Please share your thoughts on the implementation of SFBT at your agency through the BHWC SFBT initiative.
    a. What was your experience like with implementing SFBT at your agency?
    b. What was most helpful to you in implementing SFBT and using it with your clients?
    c. What changes would you recommend that would have helped you better implement and use SFBT effectively with your clients?
4. Please share your experience with being a "local champion" of your agency's SFBT implementation plan.
    a. What was your experience like with the advanced training and consultation you received as a local champion?
    b. What was most helpful in your role as local champion? What additional support or changes would you have liked to receive?
    c. How did you approach your role as local champion? What sorts of contacts or support did you provide to the other clinicians using SFBT at your agency?
    d. Other than the training and support through BHWC, what kinds of support did your agency provide you to help in your role as local champion?
5. Please share your recommendations for the next phase of the BHWC integrated care initiative.
    a. Would you recommend expanding the SFBT initiative to additional integrated care agencies? Why or why not?
    b. Would you recommend that future agencies in a SFBT initiative receive the local champion component versus staff training only? Please explain.
    c. What parts of the SFBT training and implementation would you want to keep or change in the next phase of the initiative?
    d. What other trainings or initiatives do you think the BHWC should support to improve behavioral health services in integrated care settings?
6. What else would you like to share that has not already been discussed?

Appendix E

Client Evaluation Phase – Descriptive Statistics

	All Providers (n = 45)			Champion (n = 22)			Control (n = 23)		
	N	Mean/ Pct.	SD/ Range	N	Mean/ Pct.	SD/ Range	N	Mean/ Pct.	SD/ Range
Total Sessions	787			301			486		
Sessions Per Provider	45	17.49	2-64	22	13.68	2-44	23	21.13	2-64
Seen This Client Before?	784			300			484		
Yes	660	84.2%		275	91.7%		385	79.6%	
No	124	15.8%		25	8.3%		99	20.5%	
Number of Prior Sessions	670	9.61	18.8	270	8.58	11.85	400	10.32	22.3
Treatment Used	777			298			479		
SFBT only	271	34.9%		107	35.9%		164	34.2%	
SFBT plus other treatments	350	45.1%		153	51.3%		197	41.1%	
Other treatments only	156	20.1%		38	12.8%		118	24.6%	
Before Session Ratings									
Distress	785	5.25	2.46	300	5.13	2.33	485	5.33	2.53
Hope	786	5.94	2.23	301	6.12	2.34	485	5.83	2.16
Confidence	785	6.12	2.27	301	6.56	2.32	484	5.85	2.20
Goal Clarity	786	5.81	2.33	301	6.07	2.42	485	5.65	2.27
After Session Ratings									
Distress	781	4.13	2.22	297	4.18	2.20	484	4.10	2.24
Hope	782	6.99	1.94	297	7.17	1.95	485	6.88	1.93
Confidence	783	7.09	1.97	298	7.37	2.00	485	6.92	1.94
Goal Clarity	782	7.13	2.00	298	7.31	2.06	484	7.02	1.95
SFBT Fidelity	641	6.27	1.98	271	6.17	1.99	370	6.34	1.98
Plan to Meet Again?	780			300			480		
Yes	716	91.8%		289	96.3%		427	89.0%	
No	64	8.2%		11	3.7%		53	11.0%	
Number of Additional Sessions Expected	714	7.39	8.26	279	6.74	8.15	435	7.81	8.31

Note: Distress, Hope, Confidence and Goal Clarity were self-rated by clients on a 1 to 10 scale with higher numbers indicating greater levels of each construct. SFBT Fidelity was self-rated by providers on a 1 to 10 scale with higher numbers indicating greater fidelity to SFBT techniques.