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# A Mixed Methods Evaluation of an Integrated Primary and Behavioral Health Training Program for Counseling Students

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## ABSTRACT

Behavioral health provider shortages continue to grow in the United States, with the need for related services increasing as the SARS-COVID-19 pandemic persists. The implementation of integrated primary and behavioral healthcare (IPBH) practices represents one viable approach to leverage existing resources and maximize the potential for client outcomes; however, best practices for counselors within an IPBH paradigm remain unclear. We report the findings of a mixed method evaluation of an IPBH training program with 45 (36 females; 9 males;  $M_{age} = 31.65$ ) professional counseling students who predominately identified with ethnic minority identities (55%), urban residences (66%), and disadvantaged backgrounds (44%). We detected statistically and practically significant changes in self-efficacy ( $p = .01$ ,  $d = .55$ ) and interprofessional valuing and socialization ( $p < .01$ ,  $d = .76$ ), but mixed findings for variables associated with multicultural competence. Stakeholder interviews and document analysis identified four key facilitators (Financial Support; Facilitated Engagement; Witnessing Collaboration; Holistic Representation of Clients and Client Care) and four barriers (Awareness Raising and Recruitment; Logistics and Coordination; Inconsistent Culture of IPBH; Momentum Maintenance) to program success.

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Counselors; integrated primary behavioral healthcare; self-efficacy; interprofessional collaboration; multicultural competence

The United States has been experiencing a decades-long shortage of behavioral health providers across all areas of specialization (Health Resources & Services Administration [HRSA], 2020). Primary care physicians have indicated that despite improved screening and identification of individuals who may benefit from mental health treatment, successful linking to a qualified provider is often not possible (Cunningham, 2009). As a result, nearly one in four adults and one in ten youth with a mental health condition were unable to receive any treatment for their symptoms, proportions that have magnified since the onset of the SARS-COVID-19 pandemic (Mental Health America, 2020). Mental Health America found that the access gap was consistently greater among individuals who identified as minorities even when they lived in states with the greatest amounts of mental health service access. Covino (2019) indicated that the persistence of unmet behavioral health needs has been associated with costs to humanity, including

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hundreds of billions of dollars lost through absent productivity, academic dropouts, failed medical interventions, and incarceration. Therefore, it is prudent counseling professionals to identify and pursue opportunities to leverage existing behavioral health-care infrastructures and maximize the output of workforce resources.

The integrated primary and behavioral healthcare system of care (IPBH) represents a class of strategies characterized by the close collaboration of medical providers and mental health specialists during assessment, planning, management, and treatment (Hunter et al., 2017). Within this framework, the medical provider-mental health specialist dyad represents the fundamental unit of provider collaboration with other provider additions indicated by population needs and clinic resources (Ratzliff et al., 2017). The degree of integration between providers featured within a clinical care setting ranges from minimal, focusing on intentional client-related communication to co-located client care and shared practice processes (Heath et al., 2013). The benefits of IPBH include shared responsibility for client outcomes, greater accessibility of health-related data across providers, and long-term cost-effectiveness that are associated with greater efficiency and potential for empowered approaches to well-being (Aitken & Curtis, 2004; Balkin et al., 2019; Druss & Mauer, 2010; Lenz et al., 2018). By contrast, IPBH implementation may be limited by the capability of shared health information systems, relationships among providers, conflicting administrative agendas, and varied conceptualizations of treatment priorities (Heath et al., 2013). Therefore, it may be reasonable to conjecture that the moderation of these advantages and limitations may be influenced in the direction of optimal client care through provider preparation program curriculum and specialty training experiences.

While some counselor training programs are embedded within medical teaching institutions, most are not. Thus, counselor education programs tend to develop specialty programs that provide IPBH-related education and skill training while participating in enhanced experiential field experiences. Fields et al. (in press) reviewed 18 evidenced-based training interventions with 1,875 students aimed at preparing counselors and mental health professionals to work in IPBH settings. Their thematic analyses identified three key outcome domains of interest across the reviewed training programs: (a) skill development, (b) self-efficacy, and (c) interprofessional collaboration. Fields et al. reported a trend toward statistically significant changes in the intended direction over time. For example, DeBonis et al. (2015) reported increased student confidence in clinical skill use in an IPBH setting ( $p < .01$ ,  $d = .50$ ) and ability to work as a member of an interdisciplinary team ( $p < .01$ ,  $d = .58$ ) associated with medium effect sizes. Similarly, Brubaker and LaGuardia (2020) detected medium and large effect sizes for changes in self-efficacy ( $\tau_u = .93$ ) and interprofessional collaboration ( $\tau_u = .64$ ) outcomes following a 3-month training program. Agaskar et al. (2021) also found statistically and practically significant changes in beliefs about skill development ( $p < .01$ ;  $ES = 1.05$ ) and interprofessional socialization ( $p = 0.02$ ;  $ES = 0.46$ ), but mixed evidence across areas of multicultural development. No other studies identified in Fields et al.'s review reported quantitative changes in multicultural competence associated with training program completion.

Qualitative findings from studies of IPBH training interventions were associated with the salient attitudes and perceptions about IPBH practices among participants who had completed training. Johnson et al. (2015) found that while participants

regarded IPBH as a clear pathway to enhanced patient care they noted that the potential for efficaciousness may be defined by the degree of mutual respect and shared perspectives among providers in a care system. Rishel and Hartnett (2017) reported that participants believed that there was considerable value in a training curriculum that featured multiple client care activities and problems of practice. Furthermore, Rishel and Hartnett's participants reported that facilitated opportunities for IPBH practice associated with training topics were the greatest contributor to learning and skill development. Agaskar et al. (2021) participants echoed many of these sentiments while adding that the quality of speakers was a key element in promoting growth and development within an IPBH training program.

## **Problem of Practice and Evaluation Questions**

Taken together, there appears to be evidence suggesting that IPBH training programs may be a helpful avenue for increasing participant attitudes related to self-efficacy and interprofessional collaboration. However, it is unclear the degree to which participants report changes in multicultural competence, a curious gap given that many federally funded training programs prioritize medically underserved communities which have historically been more demographically diverse than communities that have adequate provider to population ratios. Furthermore, whereas previous evaluations of IPBH trainings programs have revealed salient experiences with program participation, the depiction of features that function as facilitators and barriers to program effects is underrepresented in the professional counseling literature. In response, we implemented an IPBH training evaluation. Our activities were guided by the two key evaluation questions: (a) Do participants report statistically significant changes in counseling skill self-efficacy, interprofessional socialization, and aspects of multicultural competence following a IPBH training program?; and (b) What do training program stakeholders identify as facilitators and barriers to program success?

## **Method**

We implemented a pre-experimental mixed-method evaluation design featuring a sequential exploratory approach in which the initial quantitative strategy informed the subsequent use of qualitative methodology. We synthesized the results with the intention of using qualitative findings to represent key experiences associated with observed changes in quantitative data among program completers.

## **Inclusion and Exclusion Criteria**

Participants were master's students enrolled in a Council for the Accreditation of Counseling and Related Educational Programs (CACREP) accredited counselor education program located in a medically underserved area of the central southern region of the United States. All participants fulfilled the requirements of a specialty IPBH training program funded through the HRSA BHWET program. Participants were included if they completed all program training activities, their 700-hour field

experience requirement, and all pre-post measures to identify changes associated with program involvement.

### ***Participant Characteristics***

Participants were 45 adults (36 females, 80%; 9 males, 20%) sampled from among 87 program completers (52%) with a mean age of 31.64 years ( $SD=9.92$ ,  $Range=39$ ) who predominately identified with White ( $n=20$ ; 44%) and Hispanic/Latino ( $n=19$ ; 42%) ethnic identities. The remaining participants identified as African American ( $n=5$ ; 11%), and Asian American ( $n=1$ ; 3%). Most participants identified as individuals from urban area ( $n=30$ ; 66%) with 20 (34%) reporting disadvantaged backgrounds.

### ***Measurement of Constructs***

#### ***Counseling Student Self-Efficacy***

Melchert et al. (1996) developed the Counselor Self-Efficacy Scale (CSES) to identify knowledge and skill competencies required for effective individual and group counseling practices. The CSES includes 20 self-report Likert-type items depicting degree of confidence in counseling abilities and yields an average rating where higher scores represent greater self-efficacy. Melchert et al. reported internal consistency estimates among CSES scores within the excellent range ( $\alpha = .91$ ).

#### ***Interprofessional Socialization and Valuing***

King et al. (2016) developed the Interprofessional Socialization and Valuing Scale-21 (ISVS) to measure students' beliefs, behaviors, and attitudes concerning interprofessional practice within the allied health professions. The 21 self-report ISVS items prompt ratings of agreement on a 7-point scale ranging from "a very great extent" to "not at all." Scores on the ISVS items are totaled to yield an overall representation with higher scores being indicative of greater socialization and valuing of interprofessional practice. King et al. reported internal consistency estimates for scores on the ISVS within the excellent range ( $\alpha = .98$ ).

#### ***Cultural Competence***

Jeffreys (2010) developed the Transcultural Self-Efficacy Tool (TSET) to assess healthcare students' confidence for performing essential professional activities with diverse client populations. Part three of the TSET interview was used in this study and features self-report response items rated along a continuum from "not confident" to "totally confident" that yields five subscales related to cultural-referenced Awareness (9 items), Acceptance (3 items), Appreciation (5 items), Recognition (11 items), and Advocacy (2 items). Participant responses are averaged for each subscale with higher scores representing greater presence of the construct. Jeffreys (2010) reported that reliability estimates for scores on the TSET subscales range from .87 to .95 among samples of students in healthcare programs.

## ***Interdisciplinary Training Program***

The Texas Counselors and Healthcare Integration Project (Tex-CHIP) was implemented by the counselor education program at a Hispanic-Serving Institution located in south Texas. Tex-CHIP elements were designed to train professional counseling students to provide evidence-based and culturally responsive counseling services as members of an IPBH team. The program implemented a 2-semester cohort model and provided participants with a \$10,000 cost of living stipend during their capstone field experiences, expanded practicum and internship placements at IPBH sites in their community, and developed a 6-session specialized training series aimed at the use of evidence-based practices for treating behavioral health disorders that commonly present in IPBH settings. Each training in the series was four hours in duration, featured (a) a theme [e.g., adolescent disruptive behavior], (b) a related evidence-based treatment manual [e.g., Aggression Replacement Training; Glick & Gibbs, 2010], (c) an illustrative case study, (d) a discussion from an interdisciplinary panel [e.g., pediatrician, nurse practitioner, nutritionist, psychologist, mental health counselor, and case manager] discussion to illustrative case staffing practices and collaborative treatment, and (e) education, modeling, and practice applying treatment manual elements [e.g., Week 1: Introducing Moral Reasoning]. Participants' group supervision within their counselor education program was also modified to include multicultural and interdisciplinary conceptualizations of clients during related case presentation activities.

## ***Sampling Procedures and Data Collection***

### ***Quantitative Surveys***

Once identified as eligible for participation, participants completed a survey that included demographic items, CSES, ISVS, and TSET measures. Tex-CHIP program assistants distributed surveys to participants using the Qualtrics online survey tool at the end of the academic semester prior to their practicum and again at the end of their second semester of specialized IPBH training.

### ***Qualitative Focus Groups, Individual Interviews, Training Evaluations, and Field Notes***

Tex-CHIP program assistants used email and Blackboard announcements to query participants that had completed their training requirements to identify individuals interested in providing program feedback. Among our participants, 11 (24%) indicated an interest while 8 (18%; 5 Latinx female; 2 White female; 1 Black male) completed 1 of 2, 40-minute focus groups. Second, all Tex-CHIP program assistants ( $n=4$ ; 3 White female, 1 Latinx female) completed individual interviews (Range = 14-27 minutes) as part of their exit activities from program involvement. Interviews were completed using an adaptation of the *ODU Method for Focus Groups* (Danner et al., 2018) adapted for completing field interviews with a single researcher. The ODU Method application involved: (1) defining the purpose of interviews [identifying program characteristics and activities that facilitated or impeded to student growth], (2) selecting participants [Tex-CHIP cohort participants], (3) developing an interview guide, (4) conducting field interviews [ $n=4$  Zoom;  $n=2$

telephone], and (5) analyzing data and representing findings. The interview guide covered queries related to program recruitment, support, implementation, and process elements, as well as, providing opportunities for unstructured feedback. Program assistants collected training evaluations at the end of each specialized training offering, collated materials, and stored them for accountability documentation.

## **Analytic Plan**

### **Quantitative Analyses**

**Statistical Power and Precision of Effect Estimation.** First, we completed a series of *a priori* power analyses using the G\*Power 3.1.9.4 statistical software program to determine the sample size required to detect a medium effect size for contrasts of dependent means for the CSES and ISVS scales, as well as the TSET subscales at pre- and post-*Tex-CHIP* participation intervals. The results of these analyses indicated that a minimum sample size of 34 was needed for our analytic plan to account for statistically significant differences when accounting for a Type-II error threshold of .80. Given our sample size of 45, we regard our design as sufficiently powered to allow for inferences related to statistically significant differences over time. We confirmed this through a post-hoc analysis indicating that the achieved statistical power for our design ( $1 - \beta$ ) was .90. Second, we accounted for the increased risk of a Type I error (false positive) when completing unique statistical tests across multiple dependent variables based on the same sample by applying a Bonferroni correction to probability ( $p$ ) values within our analytic plan. Specifically, the standard alpha level (.05) was divided by the number of tested TSET scales (5) to result in adjusted  $p$ -value criteria of .01. The benchmark for CSES and ISVS subscales was retained at the .05 level, but those based on the TSET subscales were reduced to .01.

**Primary Analysis.** We computed a series of paired-samples  $t$ -test using the JASP 0.14.0.0 software based on Student's formulation to evaluate the presence of statistically significant improvements evidenced by contrasts of CSES, ISVS, and TSET scores over times. The practical significance of contrasts was estimated based on the standardized mean difference of scores over time ( $d = (M_1 - M_2) / \sqrt{((SD_1^2 + SD_2^2) / 2)}$ ) and its 95% confidence interval estimates. These values were interpreted following the guidelines depicted by Balkin and Lenz (2021) and Watson et al. (2016), wherein the effect size estimate was referenced to Cohen's (1988) interpretative benchmarks for small (.20), medium (.50), and large (.80) effects, conceptualized in units of standard deviations, and situated within its comparative context of confidence interval ranges.

### **Qualitative Analyses**

**Thematic Analysis.** First, focus group participant responses were contemporaneously documented in relation to the unique prompt that they were associated with and situated within the context of the *Tex-CHIP* purpose, framework, activities, and intended outputs. Next, as topics were explored, the interviewer began the analysis process by identifying initial themes within and between prompts and encouraging participants to provide clarifications and elaborations as indicated. The interviewer



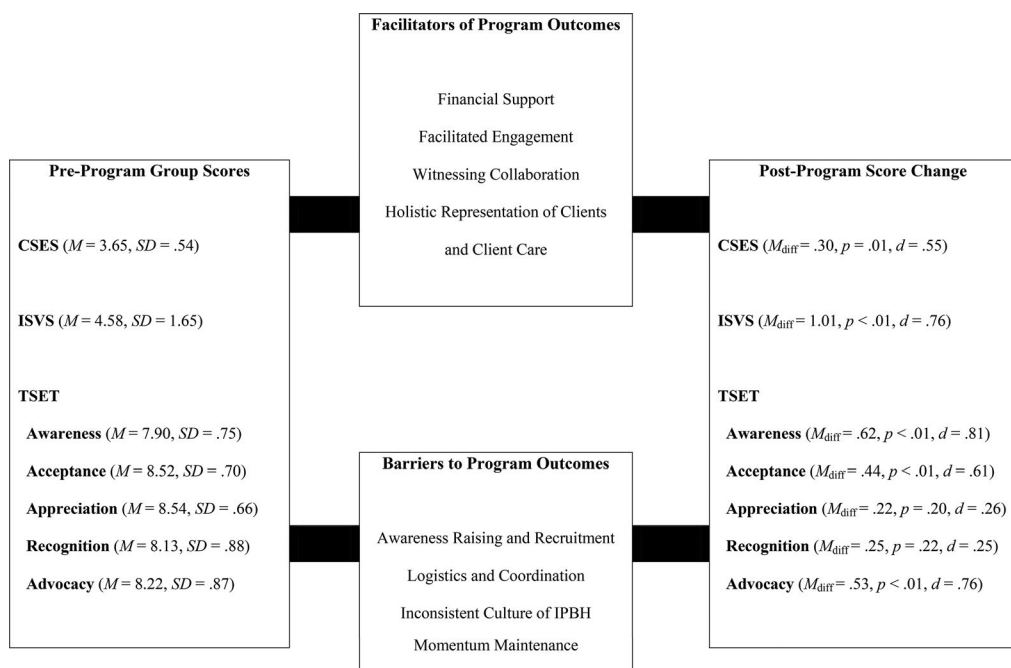
discussed summary themes and representative phrases at the end of each focus group with participants supporting the naming process. Then, individual interview analysis followed the same process with participants serving as clarifying/confirmatory agents of the initial themes from their unique perspective. Finally, themes and supportive statements were contrasted with comments in training evaluations and field notes maintained by the project directors to verify the presence, frequency, and magnitude of the identified facilitators and barriers to student development.

## Results

A synthesized depiction of our quantitative and qualitative findings are presented in Figure 1.

### *Changes in Training-Related Constructs Over Time*

Findings from the  $t$ -test revealed that participants reported statistically significant changes in scores on the CSES ( $t[44]=2.62$ ,  $p = .01$ ,  $d = .55$  [CI95 =.13, .97],  $M_{\text{diff}} = .30$ ) representing a medium effect size in which participants' sense of counseling self-efficacy tended to increase by about 55% of a standard deviation over time. Our analyses also detected statistically significant changes in scores on the ISVS ( $t[44]=3.61$ ,  $p < .01$ ,  $d = .76$  [CI95 =.33, 1.19],  $M_{\text{diff}} = 1.01$ ) representing a medium effect size in which participants' interprofessional socialization and valuing tended to increase by



**Figure 1.** Conceptualization of participant response to interdisciplinary primary and behavioral healthcare program activities.



about 76% of a standard deviation over time. While statistically significant differences were detected for Awareness ( $t[44]=3.84$ ,  $p < .01$ ,  $d = .81$  [CI95 = .37, 1.24],  $M_{\text{diff}} = .62$ ), Acceptance ( $t[44]=2.90$ ,  $p < .01$ ,  $d = .61$  [CI95 = .18, 1.03],  $M_{\text{diff}} = .44$ ), and Advocacy ( $t[44]=2.98$ ,  $p < .01$ ,  $d = .76$  [CI95 = .33, 1.19],  $M_{\text{diff}} = .53$ ), no statistically significant differences were identified for scores on the Appreciation ( $t[44]=1.27$ ,  $p = .20$ ,  $d = .26$  [CI95 = .14, .68],  $M_{\text{diff}} = .22$ ) and Recognition ( $t[44]=1.21$ ,  $p = .22$ ,  $d = .25$  [CI95 = .16, .67],  $M_{\text{diff}} = .25$ ) subscales. Statistically significant changes among the TSET subscales were indicative of effect sizes ranging from medium to large magnitudes and representing increases from 61% and 81% of a standard deviation of change.

### ***Facilitators and Barriers to Program Success***

Thematic analysis from focus group interviews with Tex-CHIP participants, program assistants, and the project director revealed four key facilitators (Financial Support; Facilitated Engagement; Witnessing Collaboration; Holistic Representation of Clients and Client Care) and four barriers (Awareness Raising and Recruitment; Logistics and Coordination; Inconsistent Culture of IPBH; Momentum Maintenance) to program success.

#### ***Facilitators of Student Growth***

***Financial Support.*** Participants indicated the cost-of-living stipend was a critical resource that provided personalized options support during their applied field experience. Because the stipend was delivered as payments to students rather than financial aid, the resource was able to be applied in ways tailored to participant necessities ranging from basic needs such as housing and transportation to professional development and leisure activities. One participant mentioned, “I was able to step away from my full-time job and move to part-time. That stipend helped because I could still make my rent, have groceries. The pressure was off and I could focus on covering my [training] hours.” Another participant indicated, “A lot of us bought new clothes so that we could look and feel professional, not just like students.” Commentary from program assistants and review of field notes also indicated several instances when individuals used their stipend to repair or purchase vehicles to get to their field experience sites, and to pursue additional professional development opportunities related to their Tex-CHIP topics. One participant noted “I went to a workshop on motivational interviewing” and another stated that they “finally joined TCA [Texas Counseling Association] and was able to attend the conference.” Aside from basic needs and professional development, participant and program assistants reported use of funding to support leisure activities that were oriented toward self-care and acknowledgement of achievements. While some used their funding for a “much needed vacation” others “bought a bicycle” or “took my family out of town to a theme park for the weekend” all of which were restorative ventures and cited as less probable without the provided financial support.

***Facilitated Engagement.*** Project director field notes and program assistant interviews indicated that the many strategies for assuring that field experience sites featured meaningful IPBH experiences were a critical aspect in assuring the intended student training experience. Activities to facilitate engagement between sites and students included

review and designation of field experience sites as featuring meaningful collaboration, not just co-location, of healthcare and other providers with mental health counseling students. One project director discussed efforts of one site to partner with a nursing training program; however, upon further inspection, it was not clear that the nursing and counseling students would be onsite at the same time, have shared client interactions, or access health service records. Similar instances led to a formal process for site designation wherein project directors and program assistants made site visits to (a) identify the multiple provider types providing client services, (b) interview mental health service providers and identify the nature and amount of interdisciplinary collaboration, (c) identify the amount of contact hours that students could reasonably expect, and (d) verify that site supervision would feature consideration of interdisciplinary work. Following this process, field experience sites received designation as a *Tex-CHIP Site* during Fall and Spring site fairs. The aforementioned details were available for review by participants and their university field experience supervisors who provided consultation about contacting sites and working with interdisciplinary providers throughout their placement. One program assistant indicated, “the Tex-CHIP designation was a big help for everyone. It let students know what site were eligible for internship and also what could be expected there by everyone.”

***Witnessing Collaboration.*** Participants and program assistants described the importance of witnessing interprofessional collaboration across two modalities- case staffing during training and in practice while at field experience sites. In both cases, participants indicated that observing professionals leverage one another’s strengths and resources provided a view of the continuum of care that is available for clients beyond mental health alone. A review of training evaluations revealed consistent citing of case staffing as a valued feature that provided insights into how related providers such as medical professionals, nutritionists, and case managers conceptualize and act upon the same mental health symptoms that are the focus of a counselor’s treatment plan. One participant voiced, “Until you get a chance to see how they all work together, it’s all just an idea in a book that you read for class” with several others providing sharing a similar sentiment. Another participant mentioned a realization about the importance of collaboration, noting that, “we were able to step back and see one clients and how many providers have something to contribute to one person’s healing.” Similarly, participants represented a distinct value of witnessing collaboration at their field experience sites, particularly in instances when they were able to not just see, but act within opportunities such as resource identification, advocating for client access, and warm handoffs. Said one participant, “It’s amazing to see different disciplinary fields using their unique strengths to support one person or family, but then you get to be a part of the process” with another describing the importance of collaboration as “You realize that its the thread that brings everything together for providing care to the whole person.”

***Holistic Representation of Clients and Client Care.*** Participants overwhelmingly remarked that they were provided with repeated opportunities to understand client experiences from a comprehensive, holistic view, and learned a great deal about the many ways to promote client development. One participant stated, it was “eye opening about the

things going on in your community and how they affect mental health” and that it “increased my understanding and about the synergy and interaction between health and MH.” These representations seemed to translate into real-world depictions of client care and how many interventions and resources were available to meet client needs. One program assistant noted, “everyone seemed to be amazed by the nutritionists. They definitely got the most questions. I even found myself taking notes.” Participants reported that they found themselves considering more options for client care when providing psychoeducation, making referrals, and advocating for treatment options. Said one participant, “It really let us practice a comprehensive approach to care.”

### ***Barriers to Student Growth***

***Awareness Raising and Recruitment.*** Participants, program assistants, and project directors reported challenges in raising awareness about the spirit of Tex-CHIP within the broader context of IPBH workforce needs. One program assistant noted:

“in the beginning, it was like ‘I can get paid for internship? Sign me up’ without a real understanding of the specifics or even wanting to know about the time commitments. There wasn’t usually an appreciation for the program. That made for some problems when holding individuals accountable later.”

This sentiment was affirmed by one participant who stated, “I knew I could use the resources how see fit, but did not know what the resources were other than money.” Another participant stated, “We didn’t know what to expect or what it was. You get a big chunk of money. It had something to do with underserved communities.” In response, project directors made efforts to start conversations about IPBH during the admissions interview process, distributed informational materials on the department list-serv, hosted regular informational sessions, and launched a website which appeared to help in some cases; however, raising awareness of Tex-CHIP purpose, activities, and requirements was a persistent challenge. These efforts continued over time, and some students elected not to pursue the training opportunity due to misconceptions; in other instances, recruitment became a more significant challenge as the greater clarity of requirements amounted to a daunting representation of additional field experience obligations.

***Logistics and Coordination.*** While the university had experience managing workforce training grants, the funding mechanism for Tex-CHIP required that students receive stipend payments rather than applying a credit toward tuition and fees. This unique approach created a universal stressor for students as the institution reconciled different amounts of payments and in some cases delayed others for weeks at a time. One program assistant noted:

“students were confused about why some people received their full stipend, some had partial amounts, and some had not received anything. It made for a few tense training sessions where it just seemed like that was the question student wanted to ask, rather than something about the training content.”

Although these stipend payment logistics were eventually resolved, the setbacks had the effect of pulling focus from project purpose, which temporarily diminished social

capital. One project director reported, “Some of these students had quit their jobs in good faith, and it was brutal seeing them stress rent and basic needs.” They continued, “With our trainers, that just felt like a challenge to maintain our side of the deal—asking a medical provider in an underserved community for 2 hours of their time and then not living up to your end of the bargain definitely lost us a few great trainers, one’s students could have learned a ton from but didn’t because they took a look at the hassle and just said *no thanks*.” Trainer loss contributed to challenges in coordinating an IPBH team for Tex-CHIP trainings, but so did the limitations of aligning that many schedules. One program assistant stated, “I never felt comfortable about a group of trainers until they walked in the door or logged on. There were multiple times that providers didn’t show up. They were usually understandable reasons, but also with little or no heads up.” These coordination barriers meant fewer providers to contribute to case staffing or training in evidence-based practices; thus, less expertise and information sharing was leveraged within participants’ training experiences.

***Inconsistent Culture of IPBH.*** The counselor education program did not have representation of IPBH in any course elements prior to the implementation of Tex-CHIP. While the purpose of Tex-CHIP was to instill this culture of IPBH, the process created challenges when making lasting changes to program identity, academic curriculum, and student development processes such as supporting case conceptualizations and integrated treatment planning during group supervision. At the program level, some of the challenges were associated with the background and training of instructors many of whom were learning about IPBH along with the students. One student noted, “it would have been nice to have more conceptualization support, not just facts. But I understand because this [IPBH] was new to my instructor, too.” One program assistant added, “In the beginning, there were integrated care requirements in classes for treatment planning and case presentations. Then as a GA in field experience, I noticed that a lot of those questions were being forwarded to me and then that those [IPBH] parts of case studies were not required anymore.” This was affirmed by one project director who noted, “there really was not much I could do to compel my colleagues. The position was that this was my project, not theirs. Why should the whole program have to change its identity?” This inconsistency within the culture of IPBH also extended to field experience sites where participants reported differing terminology and inclusiveness of IPBH activities over time. While some field experience sites consistently used the term *integrated care*, others used characterizations such as *wraparound care*, *team-based care*, and *holistic treatment*. One participant noted, “it was a challenge to switch how we talked about it in our training sessions and at our sites. What we did from site to site to be part of the team was different too. It seemed like sometimes they didn’t realize what they were doing.”

***Momentum Maintenance.*** The project director and program assistant observations indicated barriers to maintaining the momentum of the program across two levels: students and sites. One program assistant noted, “it’s extra in some ways even though the training is useful and compensation is substantial. It seemed like eventually, those weren’t motivation enough.” The motivation lag did not appear to be unique to Tex-CHIP but instead similar to that experienced as a long semester goes along and obligation fatigue

sets in. Among sites, one project director observed that intentionality tended to wane over time as the attention to novel field experiences reverted to the standard prior to the project. One project director indicated, “there definitely seemed to be a regression to the mean effect, particularly among sites that are not well-established or were emerging into integration. That left some students discouraged and others thinking they had to fight for the experience they were promised.” One participant recommended that project personnel, “Vet sites and contacts to be sure they [opportunities] are accurate- it turned out for me that what my site said I would be able to do, wasn’t an option.”

## Discussion

The results of this evaluation revealed that participants responded to the Tex-CHIP training program in ways that were anticipated based on previous literature while also providing identifiable opportunities for quality improvement. Participants reported changes in counseling self-efficacy and interprofessional valuing and socialization to similar effect size magnitudes as those in DeBonis et al. (2015) and Brubaker and LaGuardia’s (2020) program reports. For our participants, it appeared that the financial support received as a program incentive provided the opportunity to have basic needs met and focus on their professional development within an IPBH setting. Within this broader context, participants identified facilitated engagement with IPBH field experience sites and opportunities to witness collaborative approaches to client care as the key to promoting more holistic representations of client care over time. When taken together, it is plausible that these factors facilitated a reasonable degree of the growth reported by our participants. Future program iterations and those based on the Tex-CHIP model may benefit from inclusion of related opportunities or improved through intentional magnification of their presence in the core counselor preparation curriculum, and specialized training elements.

Similar to Agaskar et al. (2021), we also found varied degrees of change across variables associated with multicultural competence which ranged from statistical significance and medium to large effect sizes (Acceptance, Advocacy, Awareness) to statistical non-significance associated with small effects sizes (Appreciation, Recognition). It is possible that while focusing on clinical IPBH-related roles and activities, the program did not feature adequate opportunities to develop the attributes to stimulate growth across all TSET domains. Alternatively, it is plausible that the short-term nature of the program training experience did not represent enough time for these developmental experiences to be activated or consolidated fully. Future iterations of the program may strengthen the probability for even-handed growth in multicultural competence through the inclusion of related features during assigned training materials, interdisciplinary case conceptualizations, treatment planning collaborations, group supervision presentations, and personal reflections. It is possible that these activities may support participant perceptions of increased multicultural competence associated with program completion.

Our thematic analyses revealed additional structural barriers to optimal participant growth over time that merit inclusion in the conversation about the potential for program quality improvement. Foremost, participants reported the need to raise awareness about IPBH, Tex-CHIP features, and anticipated benefits early and often in their curricular experience. It is possible that related activities may promote a greater degree

of positive anticipation in favor of conceptual disorientation when considering inclusion which leads to a better student-program-field experience fit over time. Additionally, the participants and program assistants suggested that identifying transparent and consistent logistical processes would promote the smoothness of program administration across categories of stakeholders. While some processes are defined by institutional characteristics, other may be more amenable to improvement. Lastly, participants, program assistants, and project directors all indicated opportunities for enhancing the broader culture of IPBH and strategies that maintain the momentum associated with program activities. Such outcomes are, in part, a matter of behavioral economics and a function of the global values expressed by the counselor preparation program as a whole. Thus, it is possible that these desired attributes may need more time to become more deeply woven into the fabric of the counselor preparation program's identity. However, small change piloting and additional interviews may reveal pathways to improvement that are readily available.

## Conclusion

As behavioral health provider shortages continue to become pronounced along with magnified community needs, it is imperative to identify and implement treatment approaches that maximize resources and client outcomes. The implementation of IPBH represents a pathway for counselors to be a part of the solution; however, best practices for training have not been defined. This program evaluation demonstrates outcomes with one group of participants and the associated facilitators and barriers to program effectiveness. While some of our findings are auspicious, others merit consideration for quality improvements that may promote additional participant growth and development gains.

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