

Old Dominion University

## ODU Digital Commons

---

Counseling & Human Services Theses &  
Dissertations

Counseling & Human Services

---

Spring 2020

# Mental Health Counselors' Perceptions on Preparedness in Integrated Behavioral Healthcare in Underserved Areas

Kyulee Park

*Old Dominion University*, [kpark012@odu.edu](mailto:kpark012@odu.edu)

Follow this and additional works at: [https://digitalcommons.odu.edu/chs\\_etds](https://digitalcommons.odu.edu/chs_etds)



Part of the [Counseling Commons](#), [Counseling Psychology Commons](#), and the [Mental and Social Health Commons](#)

---

### Recommended Citation

Park, Kyulee. "Mental Health Counselors' Perceptions on Preparedness in Integrated Behavioral Healthcare in Underserved Areas" (2020). Doctor of Philosophy (PhD), Dissertation, Counseling & Human Services, Old Dominion University, DOI: 10.25777/0w74-6y16  
[https://digitalcommons.odu.edu/chs\\_etds/117](https://digitalcommons.odu.edu/chs_etds/117)

This Dissertation is brought to you for free and open access by the Counseling & Human Services at ODU Digital Commons. It has been accepted for inclusion in Counseling & Human Services Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact [digitalcommons@odu.edu](mailto:digitalcommons@odu.edu).

MENTAL HEALTH COUNSELORS' PERCEPTIONS ON PREPAREDNESS  
IN INTEGRATED BEHAVIORAL HEALTHCARE IN UNDERSERVED AREAS

by

Kyulee Park  
B.A. August 2015, College of William & Mary  
M.Ed. May 2017, College of William & Mary

A Dissertation Submitted to the Faculty of  
Old Dominion University in Partial Fulfillment of the  
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELOR EDUCATION AND SUPERVISION

OLD DOMINION UNIVERSITY  
May 2020

Approved by:

Jeff Moe (Director)

Mark C. Rehfuss (Member)

Corrin G. Richels (Member)

## ABSTRACT

### MENTAL HEALTH COUNSELORS' PERCEPTIONS ON PREPAREDNESS IN INTEGRATED BEHAVIORAL HEALTHCARE IN UNDERSERVED AREAS

Kyulee Park  
Old Dominion University, 2020  
Director: Dr. Jeff Moe

Integration of behavioral and primary healthcare (IBH) has been increasingly suggested as a model approach in serving historically marginalized populations, including rural, Healthcare Provider Shortage (HPSA), and Medically Underserved (MUA) communities (Coleman & Patrick, 1976; Wong et al., 2019). However, there is no evidence-based practices in interprofessional education and training for professional mental health counselors to serve as competent practitioners in integrated behavioral healthcare. This study examined the gap in interprofessional and counselor education literature by identifying the lived experiences and perceptions of mental health professionals in integrated settings and assessed the need areas in current counselor education. A phenomenological approach was used to capture and thematize descriptive narratives of eight (8) clinical mental health counselors. Findings of this dissertation study indicated five (5) key themes: multitude of therapist roles in IBH, identified benefits of IBH, barriers to integration and MUA care, IBH professional identity development, and educational and training needs. Clinical implications, educational considerations, and future directions for research are discussed.

Copyright, 2020, by Kyulee Park, All Rights Reserved.

This dissertation is dedicated to my parents  
for their unconditional love, support, and encouragement.

## ACKNOWLEDGMENTS

I wish to thank the Department of Counseling & Human Services at Old Dominion University and my dissertation committee members for their guidance and support: Dr. Jeff Moe, Dr. Mark Rehfuss, and Dr. Corrin Richels. A special gratitude goes out to my advisor and committee chair, Dr. Moe. Thank you very much for your mentorship, patience, and encouragement throughout my doctoral studies. I offer my sincere appreciation and love for my doctoral cohort, for countless laughs, late nights, cohort-bonding activities, and endless inspiration they have shared with me.

My completion of this project could not have been accomplished without the participants of this study. Your time, insight, and contribution to the counseling and healthcare fields are deeply appreciated and acknowledged. Together we are a step closer to creating a society of equality, equity, and empathy.

Finally, my deepest, heartfelt gratitude for my family and friends: I would not be where I am today without you.

## TABLE OF CONTENTS

CHAPTER	Page
I. INTRODUCTION .....	1
Background .....	1
Statement of the Problem .....	3
Purpose of the Study .....	3
Study-Specific Definition of Terms .....	4
Potential Contribution of the Study .....	6
II. LITERATURE REVIEW .....	7
Integrated Behavioral Healthcare .....	7
Social Determinants of Health .....	10
Rurality .....	11
Mental Health and Rural Communities .....	13
Health Professional Shortage Areas and Medically Underserved Areas .....	16
Integrated Behavioral Healthcare in Rural Communities, HPSAs, and MUAs ...	18
Interprofessional Education .....	19
Counseling and Counselor Education Implications .....	23
Critical Summary of Literature .....	26
III. METHODS .....	29
Conceptual Framework .....	29
Research Questions .....	31
Role of the Researcher .....	31
Participants and Sampling .....	32
Procedure .....	33
Data Analysis .....	35
Researcher Assumptions and Trustworthiness Strategies .....	35
IV. RESULTS .....	38
Christina's Narrative .....	39
Multitudes of Therapist Roles in IBH .....	40
Identified Benefits of IBH .....	42
Barriers to Integration and MUA Care .....	43
IBH Professional Identity Development .....	45
Educational and Clinical Training Needs .....	46

	Page
Kida's Narrative .....	48
Multitudes of Therapist Roles in IBH .....	49
Identified Benefits of IBH .....	51
Barriers to Integration and MUA Care .....	52
IBH Professional Identity Development .....	54
Educational and Clinical Training Needs .....	55
Clare's Narrative .....	55
Multitudes of Therapist Roles in IBH .....	56
Identified Benefits of IBH .....	56
Barriers to Integration and MUA Care .....	58
IBH Professional Identity Development .....	59
Educational and Clinical Training Needs .....	60
Imani's Narrative .....	61
Multitudes of Therapist Roles in IBH .....	61
Identified Benefits of IBH .....	62
Barriers to Integration and MUA Care .....	63
IBH Professional Identity Development .....	65
Educational and Clinical Training Needs .....	66
Nadine's Narrative .....	67
Multitudes of Therapist Roles in IBH .....	67
Identified Benefits of IBH .....	68
Barriers to Integration and MUA Care .....	69
IBH Professional Identity Development .....	69
Educational and Clinical Training Needs .....	70
Jen's Narrative .....	70
Multitudes of Therapist Roles in IBH .....	71
Identified Benefits of IBH .....	72
Barriers to Integration and MUA Care .....	74
IBH Professional Identity Development .....	75
Educational and Clinical Training Needs .....	76
Adrian's Narrative .....	76
Multitudes of Therapist Roles in IBH .....	77
Identified Benefits of IBH .....	78
Barriers to Integration and MUA Care .....	78
IBH Professional Identity Development .....	82
Educational and Clinical Training Needs .....	82
Kristyn's Narrative .....	84
Multitudes of Therapist Roles in IBH .....	84
Identified Benefits of IBH .....	86
Barriers to Integration and MUA Care .....	87
IBH Professional Identity Development .....	87
Educational and Clinical Training Needs .....	89

	Page
V. DISCUSSION AND CONCLUSION .....	91
Purpose, Methodology, and Results of the Study .....	93
Descriptions and Implications of Themes and Subthemes .....	95
Applications for Clinical Practice and Counselor Education .....	106
Significance of Social Determinants of Health in Counseling .....	106
Increased Access to Mental and Primary Healthcare to Vulnerable Populations .....	108
Diversified Career Opportunities for Counseling Professionals and Trainees ...	109
Counselor and IBH Practitioner Identity Development Processes .....	110
Limitations .....	112
Recommendations for Future Research .....	113
REFERENCES .....	116
APPENDICES .....	127
A. Informed Consent .....	127
B. Individual Interview Protocol .....	129
C. Personal Journaling Protocol .....	132
D. Table of Themes and Subthemes .....	134

## CHAPTER ONE

### INTRODUCTION TO THE STUDY

#### **Background**

In response to rapidly increasing needs for interprofessional, or interdisciplinary collaboration in patient care, the World Health Organization ([WHO], 2010) published the Framework for Action on Interprofessional Education & Collaborative Practice. Interprofessional education “occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes (WHO, 2010, p. 13). The WHO describes interprofessional collaboration as an innovative healthcare strategy, which would prepare collaborative practice-ready workforce, produce optimal health services, strengthen the healthcare system, and improve general health outcomes. While current healthcare and management systems in the U.S. continue to receive criticism for its fragmented services and lack of continuity of care across multiple disciplines, the call for interprofessional collaboration offers a significant shift in higher education in healthcare and helping professions.

Primary care physicians (e.g., family medicine physicians, pediatricians, general internal medicine physicians) are generalists who serve as the first point of contact in the U.S. healthcare system. Due to the nature of their practice, primary care physicians are also often the first point of contact for patients’ mental health, stress and anxiety, and emotional issues, despite that they are not trained to address these issues. Similarly, patients’ physiological and somatic concerns are well outside the mental and behavioral health providers’ scope of practice (Gleason et al., 2014). Interprofessional collaboration between the primary care physicians and behavioral health providers has been suggested as a model approach that allows healthcare to offer more holistic healthcare and management, address issues of physical and mental health comorbidity (Gleason

et al., 2014), manage complex healthcare needs of medically underserved, at-risk, or historically marginalized populations such as the LGBTQ people (Moe et al., 2018), and to provide behavioral health services to a wider range of population (Coleman & Patrick, 1976). It is imperative that professional mental health counselors are actively engaged in this emerging effort to promote interprofessional collaboration between healthcare providers.

Interprofessional healthcare collaboration, or integrated behavioral healthcare is an innate clinical component of the counseling field. School counselors traditionally have always worked in integrated settings (i.e., schools) with other professionals, such as teachers, school nurses, school social workers, and administrators. Furthermore, a rapidly increasing number of clinical mental health and family counselors are working with other helping and medical professionals in integrated behavioral settings. Although the concept of interprofessionalism has always been present in counselor education, literature specific to interprofessional collaboration education has only emerged in recent years (Johnson & Freeman, 2014). In order for counseling practitioners to successfully and effectively contribute to the growing integrated behavioral healthcare settings, it is important that we continue to explore ways to improve the systemic integration of primary and mental health care.

One of the distinct benefits of integrated behavioral healthcare surfaces in rural, health professional shortage, and medically underserved areas (Lee et al., 2019; Redford, 2019; Wong et al., 2019). Rural residents encounter a unique set of challenges including, lack of accessible regular source of healthcare, financial difficulties, lack of insurance coverage, and medical illiteracy (Lane et al., 2008; Rainer, 2010; Watanabe-Galloway et al., 2015). Overall, poorer health outcomes are reported for people living in rural and remote areas, including lower life expectancy, greater levels of chronic disease, and higher rates of hospitalization from injuries.

For isolated residents in rural communities with lack of accessible and regular source of healthcare, the integrated behavioral healthcare approach can serve as a valuable resource that may decrease the overutilization of urgent and emergency health care while improving the overall quality of life.

### **Statement of the Problem**

Although the integrated behavioral healthcare approach has been increasingly suggested as a model approach in serving rural, healthcare provider shortage, and medically underserved communities, there is no evidence-based, best practices in interprofessional education and training for professional mental health counselors in place at the time of study. This study seeks to examine the gap in interprofessional literature by identifying the lived experiences and perceptions of mental health professionals in integrated settings and to assess need areas of current interprofessional education in the field of counseling.

### **Purpose of the study**

The primary purpose of this dissertation study is to investigate mental health practitioners' lived experiences in working with rural, health professional shortage, and medically underserved areas in integrated behavioral healthcare settings as well as their perceptions of their educational preparation. The researcher aims to answer the following questions:

- What are the mental health practitioners' lived experiences in working with rural, health professional shortage, and medically underserved areas in integrated behavioral healthcare settings?

- What are the mental health practitioners' perceptions of their CACREP educational preparation regarding their integrated behavioral healthcare practice in working with rural, health professional shortage, and medically underserved areas?

## **Study-Specific Definition of Terms**

### ***Primary Care***

The American Academy of Family Physicians (AAFP, n.d.) defines primary care as “care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis” (para. 4). In this study, primary care refers to the “first point of entry into the health care system and as the continuing focal point for all needed health care services” (AAFP, n.d., para. 5) provided by trained primary care physicians with specializations in Family Medicine, Internal Medicine, or Pediatrics.

### ***Behavioral Health***

In this study, Peek and the National Integration Academy Council's (2013) definition of Behavioral Health Care will be adopted. It is defined as “an umbrella term for care that addresses any behavioral problems bearing on health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors” (p.9).

### ***Integrated Behavioral and Primary Healthcare (IBH or IBPH)***

IBPH combines “medical and behavioral health services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, mental health or substance abuse disorders” (Peek & the National Integration Academy Council, 2013, p. 9). Generally, IBPH can range from informal referral systems between primary care physicians and

mental health counselors to a complete, systemic integration of two services in a shared space. For this proposed study, the researcher will consider IBPH as those that qualify as at least Level 3: Basic Collaboration Onsite, which is one of the SAMHSA-HRSA Center for Integrated Health Solutions classifications. At Level 3, “behavioral health, primary care and other healthcare providers work in same facility ... where they have separate systems, communicate regularly about shared patients, ... collaborate, driven by need for each other’s services and more reliable referral, meet occasionally to discuss cases due to close proximity, and feel part of a larger yet non-formal team” (SAMHSA-HRSA Center for Integrated Health Solutions, n.d., p. 10). Throughout the study, the terms IBPH and integrated behavioral health (IBH) will be used interchangeably.

### ***Interprofessional Education (IPE)***

The World Health Organization (WHO, 2010) stresses that “interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (p.7) in the Framework for Action on Interprofessional Education & Collaborative Practice.

### ***Rurality***

Generally, ‘what is not urban’ is considered rural according to the U.S. Census Bureau (Ratcliffe et al., 2016) and all non-metropolitan area is considered rural. Urbanized areas are designated for communities of 50,000 or more people and urban clusters of at least 2,500 and less than 50,000 people (Health Resources & Services Administration, n.d.). However, many metropolitan areas in the U.S oftentimes include counties that are rural in nature. In order to more accurately identify rurality in the U.S. researcher will adopt the Goldsmith Modification (U.S. Census Bureau, 2010) for the purpose this study. The Goldsmith Modification lists all non-

metropolitan rural counties as well as metropolitan rural counties in the U.S. and is available for review on the Health Resources & Services Administration website.

### ***Healthcare Provider Shortage Areas (HPSA)***

HPSAs are “designations that indicate health care provider shortages in primary care, dental health; or mental health” (HRSA, n.d., para. 1) based on geography, population, and available facilities. HPSAs are designated by the HRSA based on the population-to-provider ratio, level of income, travel time to health care, and number of eligible healthcare providers that accept Medicaid and or a sliding fee scale.

### ***Medically Underserved Areas (MUA)***

MUAs are areas designated by HRSA as “having too few primary care providers, high infant mortality, high poverty or a high elderly population” (HRSA, n.d., para. 1).

### **Potential Contribution of the Study**

Addressing the unique healthcare complications of rural, healthcare provider shortage, and medically underserved populations is a significant social justice and advocacy issue in the healthcare field. However, to this date, literature and research on rurality, healthcare provider shortage, and integrated behavioral and primary healthcare have been underrepresented and overlooked in counseling and counselor education. With the increasing needs for innovative and cost-effective healthcare infrastructure for underserved populations, it is not only urgent, but also fundamental to explore the educational and professional experiences and perceptions of mental health practitioners in IBH practices. Exploring counselors’ clinical interprofessional experiences will help define the gap in counselor education and training. This study seeks to further contribute to the evaluation and development of competence-based interprofessional counselor education by examining counselors’ perceptions of their own educational preparedness.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

In this chapter, the researcher defines critical terminologies and concepts pertaining to this study, including integrated behavioral healthcare, interprofessional education, rurality, health professional shortage areas (HPSAs) and medically underserved areas (MUAs). The researcher will also discuss this study's practical and conceptual implications in the field of counseling and counselor education. Literature on integrated behavioral and primary healthcare generally indicates its promising efficiency in medically underserved areas and capability to enhance the currently fragmented healthcare structure in the U.S. However, much less attention has been given to the adequate interprofessional education and practical training for the behavioral healthcare providers (e.g., professional mental health counselors, licensed clinical social workers). Mental health counseling literature and research on IBPH and rurality/HPSA/MUAs are also significantly underrepresented. With the increased and proposed needs for more systemic integration and training, it is not only timely to investigate the current educational and professional experiences of mental health counselors in underserved IBPH communities, but also crucial to develop interprofessional education in counselor education. Therefore, this study seeks to employ a qualitative research design to explore an underrepresented area of counselor education.

#### **Integrated Behavioral Healthcare**

The Health Resources & Services Administration (HRSA) is at the forefront of the active promotion, education, and professional training of integrated behavioral healthcare (IBH), through various federally funded initiatives such as the Health Center Program, Ryan White HIV/AIDS Program, and Health Workforce Training Program. HRSA (n.d.) defines integrated

behavioral health as “... when a team of providers, including physicians, nurse practitioners, behavioral health clinicians, community health workers, home visitors, and other health care providers, work together to address patient needs to achieve quality outcomes for every individual in care” (para. 1).

IBPH yields a wide variety of significant individual, organizational, and societal benefits, such as decreased cost of care, decreased caregiver burden, decreased rates of acute care utilization (Assefa et al., 2019), increased overall effectiveness of health services retained (Lenz et al., 2018; Schmit et al., 2018), increased health outcomes (HRSA, n.d.), and efficacy in addressing mental and chronic health comorbidity as well as untreated or undiagnosed mental health disorders (Schmit et al., 2018; Yoon et al., 2013). Additionally, a meta-analysis revealed that IBPH was related to decreased symptoms of mental health disorders, such as depression and post-traumatic stress disorder immediately during the time of care and over time compared to its traditional counterpart (Lenz et al., 2018). Over the years, both the medical and mental health fields have been gradually recognizing the increasing need to provide holistic, interdisciplinarily collaborative care for effective treatment of complex physical and mental health concerns and sustainable management of health outcomes (Assefa et al., 2019).

Incorporation of behavioral and mental health counseling can be employed in various settings, such as in school system or prison rehabilitation programs; however, in this study, the researcher will focus on integrated behavioral and primary health care (IBPH). IBPH combines behavioral and primary healthcare in order to address commonly experienced, but integral to basic health and wellbeing concerns such as “stress-linked physical symptoms, health behaviors, mental health, or substance abuse disorders” (Peek & National Integration Academy Council, 2013, p.9). IBPH coordinates screening, delivery, and management of such health services in one

setting, organized by various healthcare providers including primary care physicians, nurses, mental health counselors, social workers, and patient advocates.

### ***Levels of Collaboration and Integration***

IBPH programs are oftentimes sorted into six categories based on the level of their behavioral and primary healthcare integration (SAMHSA-HRSA Center for Integrated Health Solutions, n.d.). In Coordinated (i.e., Level 1: Minimal Collaboration and Level 2: Basic Collaboration at a Distance) facilities, behavioral and primary healthcare providers practice in separate facilities under separate systems. They are largely characterized by referral-based communication between the behavioral and primary care practitioners. In Co-located (i.e., Level 3: Basic Collaboration Onsite and Level 4: Close Collaboration Onsite with Some System Integration) practices, behavioral and primary care providers practice in same facilities and share some level of administrative systems, such as scheduling or medical records. At these levels of integration, healthcare providers develop a sense of being part of a larger team and actively communicate with each other to coordinate health care. In Integrated (Level 5: Close Collaboration Approaching at Integrated Practice and Level 6: Full Collaboration in a Transformed/Merged Integrated Practice) facilities, the involved healthcare provider team share the same space, facility, and systems. These levels are often characterized by a shared concept of team care, regular communication and collaboration of care, and professional support for the integrated system of care. Each level is not without limitations; however, each advancement of the levels is positively related to more holistic patient care, improved health outcomes, and healthcare provider satisfaction (SAMHSA-HRSA Center for Integrated Health Solutions, n.d.).

## **Social Determinants of Health**

The social determinants of health (SDOH) is a term coined to describe “the conditions in which people are born, grow, live, work, and age and can affect a wide range of health risks and outcomes” (Tumber et al., 2019, p. 22). SDOH can range from housing stability, levels of food security, levels of income, safety of residence/neighborhood, and quality of public education. Poor SDOH is strongly correlated with various health risks and poorer health outcomes. In rural settings, it is suggested that hospitals lack intensive care units, nursing facilities, psychiatric units, rehabilitation units, and general medical healthcare providers (Agency for Healthcare Research and Quality, n.d.; Vogel et al., 2017). Additionally, many negative SDOH qualities reflect characteristics of many rural and medically underserved communities. For example, such communities oftentimes lack access to and availability of public transportation, which adversely impacts employment and educational opportunities (Artiga & Hinton, 2018). Similarly, access to healthy food options, walkability of the neighborhood, and availability of community parks and playgrounds are common SDOH that rural and underserved communities are generally short of. These disparities in the social determinants of health shared by most rural and medically underserved communities are a critical social justice issue. IBPH is one of the model approaches that can significantly improve the community health infrastructure by decreasing the health disparities.

Tumber et al. (2019) suggested that in order to decrease stigma and increase awareness, SDOH screening needs to be more universal in clinical settings. Healthcare providers can benefit from actively utilizing tools such as a SDOH screening questionnaire in their everyday practice, as more frequent and thorough screening can result in early interventions for medium- to high-risk patients with poor social determinants of health. In order for the SDOH screening to be most

effective and sustainable, healthcare providers must be able to identify high-quality referral resources and have timely access to those referrals. In IBPH settings, trained behaviorists such as professional mental health counselors can provide this screening-to-care system.

## **Rurality**

The classification of urban, suburban, and rural areas has been an interesting, yet underdiscussed topic. As the population has grown exponentially over the past two centuries, defining urban areas has continuously changed over time, and rural areas have historically been defined as “all territory, persons, and housing units not defined as urban” (U.S. Census Bureau, n.d.). Many studies and federal agencies suggest that there is no consensus in the definition or classification of rurality, and each classification system posits its own merits and challenges. The U.S. Census Bureau uses population and development density as a measurement for urban-rurality classification (Ratcliffe et al., 2016). Specifically, a geographical tracts or blocks would be measured for its criteria such as population density, land cover, number of airports. Once a geographical area is defined as “urban,” everything not urban becomes “rural.” Ratcliffe et al. (2016) introduced the three rurality categories of (1) completely rural, (2) mostly rural, and (3) mostly urban based on the proportion of the population in U.S. counties, and yielded an interesting outlook on rurality. For example, Accomack County of Virginia with 33,164 residents in 2010 Census is scored 100 % on the rurality scale (i.e., completely rural; no identified urban areas in the county), while the Stanley County in South Dakota is scored 42.5% rural (i.e., mostly urban; more than 50% of the county identified as urban) with only 2,966 residents. Each rurality category had a wide range of population spectrum that crossed other categories, which portrayed one of many complexities of urban-rural grouping (Ratcliffe et al., 2016).

Lack of consensus in definitions and a complex classification system is not the only challenge that rural America faces. Studies in various disciplines have found that rurality surpasses the mere geographical classification and differences on the map and significantly impacts almost all aspects of life, such as health, education, and socioeconomic status. This section of the literature review supports evidence of clear health disadvantages among rural community residents, concerning health outcomes, access to health, and the quality of healthcare (Anderson et al., 2015). The National Rural Health Association (NRHA, n.d.a) is a dedicated nonprofit organization with a mission to improve general rural health through leadership, education, training, and advocacy. Rural residents typically encounter a wide array of barriers to healthcare compared to their urban and suburban counterparts. The NRHA (n.d.b) identified workforce shortage problems, socioeconomic factors, and health inequity as the main contributors of healthcare disparities, which is consistent with rurality literature.

Anderson et al. (2015) examined the intersectionality of rurality and local, state, and federal policies on the population's health behaviors, clinical care, social and economic factors, and the physical environment based on the County Health Rankings. The health behavior data indicated that rural residents are (1) more likely to be obese or overweight, (2) more likely to have type 2 diabetes, (3) more likely to smoke cigarettes, (4) more likely to consume or develop dependency on alcohol, (5) less likely to consume fruits and vegetables, (6) less likely to engage in physical activities. It is also reported that there is a higher rate of suicide among rural residents per capita.

Clinical care data revealed that rural residents are (1) less likely to have health insurance, (2) less likely to have medical specialists per 100,000 people, and (3) more likely to have preventable hospital stays for acute and chronic conditions. Although the high school dropout

rate has been steadily decreasing in the rural communities, rural residents are still less likely to have a bachelor's degree compared to their urban or suburban counterparts. Lastly, rural residents are more likely to experience asthma morbidity. Rural residents are more likely to experience unintentional injuries and deaths due to poisoning, suffocation, and falls, and more likely to die from motor vehicle accidents. There are multiple social and economic factors that contribute to the high mortality rates, including fewer medical facilities, longer emergency response time, and longer pre-hospital wait times. Mortality rates for rural residents generally has been higher than their urban and suburban counterparts since 1968, according to the Center for Disease Control and Prevention (CDC). Existing literature suggests that these geographic and socioeconomic isolation and their associated health disadvantages that the rural residents commonly experience can be moderated by integrating primary and behavioral healthcare (Lee et al., 2019; Redford, 2019; Wong et al., 2019).

### **Mental Health and Rural Communities**

Health disparities between urban and rural communities have been well-documented in various medical and health professions literature. Specifically, rural residents' lack of access to healthcare and resources has been a rapidly growing concern of social significance as the rural population with complex chronic illness is increasing (Seright & Winters, 2015). Studies suggest that almost half of the U.S. rural residents live with at least one chronic illness, yet rural communities are grossly underserved in terms of healthcare provider availability. Literature stresses that individuals who identify as racial and ethnic minorities, are socioeconomically disadvantaged, lack health insurance, and reside in rural or remote areas are at a significantly greater risk of having under-diagnosed and under-treated substance use and mental disorders (Chan et al., 2015; Wang et al., 2005). Struggles with recruitment and retention of rural

healthcare providers have been linked to lack of educational preparation for rural and underserved community healthcare (Hendrickx & Winters, 2017).

In the U.S., geriatric population, veterans, and rural residents are at risk for higher suicide rates (Arbore, 2019). While there is more research and organizational support for suicide prevention programs for U.S. veterans, older rural residents, or any individuals with more than one minoritized identities in rural areas are frequently left in the healthcare blind spot. Geriatric individuals in rural areas struggle with multiple layers of challenges in accessing healthcare and resources, acquiring transportation to healthcare, and encountering social stigma associated with seeking mental health treatment (Arbore, 2019). Many rural Americans face multifaceted threats to healthcare, and rural individuals with historically marginalized identities experience more adverse risk factors regarding healthcare access. For example, veterans are more likely to live in rural areas where access to healthcare is less than optimal as well as to have physical disabilities, mental illness, and/or substance use disorders (McCarthy et al., 2012). Subsequently, McCarthy et al.'s (2012) research indicated that veterans living in rural areas showed increased suicide rates than their urban counterparts.

Substance use is another concern in many rural counties in the U.S. In Joudrey et al.'s 2019 study, 2010 U.S. Census coordinates for five states (i.e., Indiana, Kentucky, Ohio, Virginia, and West Virginia) were obtained and analyzed to determine the mean drive time to the nearest opioid treatment programs (OTPs) for urban and rural communities. The study revealed that while the mean drive time to the nearest OTP was 37.3 minutes and the mean for urban areas was 45.1 minutes, the mean for rural areas increased up to 86.4 minutes. Depending on the type of substance treatment needed (e.g., opioid, dialysis, etc.), some treatment requires frequent and regular – as often as six times per week – visits to the substance treatment facilities. The rural

healthcare infrastructure needs significant and sustainable improvement in order to address the issues of increasing prevalence of substance use disorder and lack of access to healthcare.

Integrated behavioral and primary healthcare has been suggested as a cost-effective solution to address the healthcare provider shortage concern in remote and underserved areas; however, these communities also struggle with healthcare provider recruitment and retention as well as overall inadequate education and training of healthcare practitioners to serve this population (Hendrickx & Winters, 2017; Chan et al., 2015). In a 2015 analysis of screening and monitoring substance use statistics, only 13.6% of patients in rural areas received follow-up monitoring for their substance use concerns compared to 41.4% in non-rural areas. Additionally, although rural patients with substance use issues showed greater psychiatric complexities, they were least likely to receive follow-ups. Even though substance misuse is shown to be a substantial problem in rural and remote areas in the U.S., more than a quarter of rural community health clinic patients were not screened and rural residents with larger travel distance to the clinics were especially less likely to receive a follow-up. The statistics show that residents in rural and remote areas are disproportionately underserved in their healthcare system and the rural practitioners may be overburdened due to the provider shortage.

Because of the general lack of practicing physicians or other healthcare providers in rural communities, some rural medical facilities have been expanding their scope of specialized services, as evident by the development of rural intensive care units within critical access hospitals (Seright & Winters, 2015). A recent HRSA (2017) survey indicated that only 16 percent of registered nurses (RNs) reside in rural communities. Fiske et al. (2005) suggested that one of the reasons for an increased suicide risk for rural residents in the U.S. is that there is a significant mental health provider shortage in rural communities. For instance, there is no urban-

rural differences in prevalence of depression; however, it is clear that there are fewer mental healthcare facilities and providers in rural areas. The U.S. Department of Health and Human Services (2003) acknowledged that essentially all rural counties in the U.S. are considered as healthcare provider shortage areas. Although there is currently no demonstrated causality between the general poorer mental health outcomes in rural areas and the healthcare provider shortage, it is strongly inferred that improvement in healthcare infrastructure and increase in mental healthcare providers can mediate these issues.

### **Health Professional Shortage Areas and Medically Underserved Areas**

Urban resident population surpassed the rural population for the first time in the U.S. in the 1920s (Redford, 2019). In 2010, it was estimated that nearly 80 percent of the U.S. population resided in urban areas. Alongside with the gradual decrease of population and rapid aging of rural communities, rural communities are overrepresented in the Primary Care Health Professional Shortage Areas (HRSA, 2019; Redford, 2019). HRSA designates Health Professional Shortage Areas (HPSAs) based on geographic area, population groups, and types of facilities using various sources of data (i.e., National Provider Identifier, Environmental System Research Institute, Census Bureau, Centers for Disease Control and Prevention National Vital Statistics, and Health Resources and Services Administration's Uniform Data System). Once State Primary Care Offices (PCOs) submit the HPSA designation applications, HRSA scores the application based on the population to provider ratio, percentage of the population below 100% of the Federal Poverty Level, and travel time to the nearest source of care outside the HPSA designation. HPSA Find (<https://data.hrsa.gov/tools/shortage-area/hpsa-find>) offers location-based HPSA designation information. For example, The City of Norfolk in Virginia has six non-

rural HPSA designations, of which three are primary care shortage, one dental health, and two mental health shortage.

Healthcare provider shortage is not an emerging issue. Some medical specialties are already in critical shortage, and almost all types of healthcare professions are experiencing or expecting provider shortages. It was projected that between the years of 2002 and 2012, approximately 5.3 million full-time healthcare positions would become available and needed, while the number of trained healthcare professionals of all types combined would never meet the needs of the demand (Sheldon, 2011). Healthcare provider shortage posits an incredible danger to public health, prevention and intervention of illness, and health outcomes. Not all HPSAs are classified as rural areas; however, almost all rural counties qualify as the HPSA in the U.S. The provider shortage particularly threatens the general health of rural communities where healthcare provider recruitment and retention is a major challenge. Nonetheless, in HPSAs, integration of primary and behavioral healthcare is extremely limited.

Similarly, Medically Underserved Areas (MUAs) are scored using the provider per 1,000 population ratio, % population at 100% of the Federal Poverty Level, % Population age 65 and over, and infant mortality rate (HRSA, 2019). MUA Find (<https://data.hrsa.gov/tools/shortage-area/mua-find>) offers similar services to the HPSA Find. Not all MUAs are in rural settings, but a large portion of rural America is designated as MUAs. Most healthcare provider shortage areas also qualify as medically underserved areas; however, MUAs do not examine behavioral or mental health practitioner per population ratio whereas HPSAs qualifications indicate primary, dental, and mental health providers. In the City of Norfolk, three areas (i.e., Norfolk City, Norfolk Central, and Norfolk Northeast) are designated as non-rural MUAs. In this study, the HPSA Find and MUA Find tools will be utilized to determine participation eligibility.

### **Integrated Behavioral Healthcare in Rural Communities, HPSAs, and MUAs**

In order to examine the practitioners' perceptions of integrated behavioral and primary care, a cross-sectional survey study asked questions regarding physicians' and other healthcare providers' perceived outcomes of interprofessional care, types of practice facility, types and numbers of healthcare professionals, PCP on-site availability, and travel distance for a PCP to reach the facility in rural communities (Wan et al., 2018). A total number of 65 participants returned the survey. The results indicated that the practitioners generally agreed on the effectiveness of interprofessional care on "improved patient outcomes, increased clinic efficiency, and better care coordination and patient follow-up" (Wan et al., 2018, p.221). Wan et al. (2018) further stressed that the healthcare providers generally favored the interprofessional care in medically underserved areas and that interprofessional care may significantly "extend the capacity of physicians when they are not immediately available" (Suter et al., 2012). Studies suggest that IBPH in rural, medically underserved, and healthcare provider shortage areas can be an effective strategy to address complex healthcare needs.

Unfortunately to this date, there is no research or educational curricula that specifically target behavioral healthcare providers. Many medical schools and residency programs have begun to incorporate rural and community healthcare training more routinely and systematically in their curriculum as family physicians in the U.S. provide more than 40 percent of rural healthcare (National Rural Health Association, n.d.). However, there is a scarcity of critical literature reviews of, research on, and educational or training curricula for preparing mental health counselors to become competent behavioral healthcare providers in IBPH in rural and medically underserved communities. This study aims to shed light on educational and

professional preparation needs and requirements for professional mental health counselors and contribute to the counselor education field.

Mental health counselors have a unique set of skills and expertise to become an integral part of the integrated behavioral healthcare team (Park et al., in press). Although counseling programs' educational and training emphasis on communication, collaboration, consultation, advocacy, and multicultural counseling/supervision strongly align with key elements of successful IBPH, IBPH as an evidence-based model is generally underrepresented in the counseling literature (Lenz et al., 2018) as well as in practice (Assefa et al., 2019). Successful and sustainable implementation of IBPH innately requires ongoing multidisciplinary and interprofessional collaboration. Researchers have identified that a lack of a clear consensus in understanding of IBPH among multiple health disciplines as one of the major barriers in promoting and implementing IBPH (Assefa et al., 2019; Lenz et al., 2018). Furthermore, while most healthcare educational accreditation bodies (e.g., Accreditation Council for Graduate Medical Education and Council on Social Work Education) emphasize the importance of preparing IBPH-competent practitioners, systemic IBPH education and training is minimally incorporated in their accreditation guidelines.

### **Interprofessional Education (IPE)**

With the increasing international and national recognition and support for interprofessional education (IPE), in 2011, the Interprofessional Education Collaborative (IPEC) Panel published a report on Core Competencies for Interprofessional Collaborative Practice. The report defines interprofessional competencies in health care as: “integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate

to improve health outcomes in specific care contexts” (IPEC, 2011, p. 2). Interprofessional competencies are highly relevant and appropriate to be included in counselor education curriculum as the Patient Protection and Affordable Care Act strongly encourages and to foster interprofessional relationships between mental health counselors and primary care physicians (Beacham, Kinman, Harris, & Masters, 2012; Cox, Adams, Loughran, 2014). Currently, a total of 20 national associations, such as American Psychological Association (APA), Association of American Medical Colleges (AAMC), Association of Schools and Programs of Public Health (ASPPH), Association of Schools of Allied Health Professions (ASAHP), and Council on Social Work Education (CSWE), serve as IPEC’s institutional members (IPEC, 2016).

With counselors deployed in a variety of settings with complex issues, counselors and their professional organizations have begun to promote interprofessional collaboration as a way to effectively address complex human issues in treatment (Mellin et al., 2011). The accreditation board for graduate level counseling programs, Council for Accreditation of Counseling and Related Programs ([CACREP], 2015) has incorporated the necessity of integrated and interprofessional care into their standards of practice. Examples of the CACREP standards that address interprofessional collaboration include:

- *2.F.1.b*: The multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation
- *2.F.1.c*: Counselors’ roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams
- *5.D.2.b*: Relationships between clinical rehabilitation counselors and medical and allied health professionals, including interdisciplinary treatment teams
- *5.D.3.b*: strategies for interfacing with medical and allied health professionals, including interdisciplinary treatment teams
- *5.H.3.l*: consultation with medical/health professionals or interdisciplinary teams regarding the physical/mental/cognitive diagnoses, prognoses, interventions, or permanent functional limitations or restrictions of individuals with disabilities

Even with the organizational push for interprofessional collaboration between mental health and related fields, counseling professionals have produced very little research on IPE so far (Johnson & Freeman, 2014). Johnson and Freeman (2014) addressed the need for mental health counselors and counselor educators to become familiar with IPE and to incorporate IPE into counseling programs. Through IPE, counselors are better able to address complex issues in practice, understand other professionals and their roles and power, and gain a better understanding of their own counselor identity (Bridges et al., 2011; Johnson & Freeman, 2014).

This proposed research will expound on current CACREP guidelines regarding its preparation of mental health counselors in IBPH settings serving rural, medically underserved, and health provider shortage communities in the U.S. Furthermore, by examining counselors' practical experiences in the IBPH settings in this study, the researcher hopes to create a foundation in developing a more standardized and effective IPE curriculum and training in counselor education.

### ***Core Competencies for Interprofessional Collaborative Practice (IPEC, 2011; 2016)***

Competence-based training and education first emerged in order to supplement common limitations of knowledge- and attitude-based approaches (Barr, 1998). It is now widely trusted that competence-based training models for healthcare practitioners are better suited to optimize complex patient/client health outcomes. IPEC (2011) developed four main domains of Interprofessional Collaborative Practice, which comprises of: (1) Values and ethics for interprofessional practice, (2) Roles and responsibilities for collaborative practice, (3) Interprofessional communication practices, and (4) Interprofessional teamwork and team-based practice. Under these guidelines, interprofessional collaborators are expected to effectively advocate for their individual professions with respect for other professions, contribute to

healthcare delivery within their scope of practice while communicating with other professions, practice team-based problem solving, and apply patient-centered and community-focused approaches in healthcare in an efficient manner.

This established and interprofessional utilized set of core competencies are also useful in analyzing the current trends in interprofessional education (Doll et al., 2013; Hepp et al., 2015). In a 2013 comparative analysis study of 18 students from various disciplines (i.e., medicine, nursing, pharmacy, dentistry, occupational therapy, and physical therapy), Doll et al. (2013) examined the qualitative use of the IPE core competencies in didactic and clinical curriculum of an interprofessional education course (Doll et al., 2013). The students were asked to describe their experiences in IPE, particularly, “difficulties encountered working as a team, value of IPE, lessons for future practice and learning that occurred around self-profession and other professions” (p. 194). Emerged themes included, *prioritization of patient care goals, holistic versus non-holistic care, team interaction skills, knowledge of other professions’ scope of practice, and participants view/belief in other professions as resourceful and valuable* (Doll et al., 2013). This research identified two important components of interprofessional education: (1) qualitative research in students’ experience in IPE or IBH can be a valuable source of program evaluation and future program development and (2) IPE core competencies closely align with and represent values that students gain through interprofessional education. Consequently, the researcher plans to refer to the IPE core competencies in the proposed study’s data analysis.

Doll et al.’s (2013) qualitative study on interprofessional education experience of students in various healthcare disciplines is groundbreaking in a way that it is one of the first and few studies that investigated healthcare learners’ understanding of and experience with IPE. However, it is critical to acknowledge that the IPE course this research studied did not include

any behavioral and mental health students, who are unquestionably an integral part of the integrated behavioral healthcare team. The proposed study will lessen the gap in literature by focusing on the lived experiences and perceptions of professional mental health counselors that are employed as behavioral healthcare providers in IBPH settings. Additionally, interviewing current professionals with clinical and real-life experiences in IBPH settings is believed to be more effective and appropriate for analyzing levels of preparation on IBPH in current counselor educational curriculum, which is a newly emerging area of focus in counseling.

### **Counseling and Counselor Education Implications**

It was not until the 1970s that rural and community mental health needs gained national and organizational attention (Smalley et al., 2010). Healthcare provider shortage, high practitioner turnover rate, and the lack of educational and practical training specific to rural and remote residents in the U.S. started to gain more attention with the foundation of the Office of Rural Health Policy and the National Rural Health Advisory Committee in 1987. Despite these federal, state, and local efforts to address unique primary and mental health needs of rural residents, many rural Americans continue to experience adverse challenges regarding their healthcare and services (Smalley et al., 2010). HRSA (2005) has contributed these multi-layered barriers to healthcare infrastructure improvement to “accessibility, availability, and acceptability of mental health services” (p. 480).

It is suggested that an integrated behavioral and primary healthcare model is a cost-effective approach in improving access to healthcare in rural and underserved communities (Basu et al., 2017). It is estimated that roughly 18% of all adult Americans are affected by behavioral health issues that increase morbidity, mortality, and healthcare costs (Basu et al., 2017; Davis et al., 2013). While urban residents in the U.S. generally are more connected to various healthcare

resources and have easier access to transportation and low-cost healthcare clinics, rural residents often need to travel more than an hour to receive healthcare. Consequently, the greater travel time and distance results in underutilization of healthcare services in rural and health provider shortage areas. IBPH can greatly reduce the travel distance that rural and underserved residents have to endure to receive healthcare, connect the rural residents with appropriate resources, and address a wide array of behavioral concerns including unhealthy habits and substance use in one setting. Many behavioral health topics such as substance use, diet, exercise, basic psychoeducation can be integrated in primary healthcare settings without the presence of psychiatrists or neurologists.

For example, a primary care behaviorist model (PCBM, Klein & Hostetter, 2017) involves brief screening for common behavioral concerns such as depression, anxiety, alcohol use, and tobacco use at the primary healthcare site. At the time of visit, a behaviorist (e.g., psychologist, licensed clinical social worker, and licensed mental health counselor) would provide brief in-person behavioral treatments in addition to the brief screening. After a visit to the PCBM facility, a care manager (e.g., psychiatric nurse or behaviorist) would provide phone follow-ups regarding primary and behavioral health concerns discussed. These brief behavioral screening and interventions can be coded as part of the Medicare Part B billing code as well. Basu et al. (2017) strongly argue that the new Medicare billing code for behaviorist intervention can increase the financial viability of integrated clinics, especially in rural and medically underserved areas. Using the microsimulation model, Basu et al. (2017) compared costs and revenues of the Collaborative Care Model (CoCM: active utilization of psychopharmacology follow-ups by psychiatric or registered nurses in primary care) and PCBM approaches in both urban and rural high-poverty settings. The results indicated that the CoCM approach would tend to gain more net revenues compared to the PCBM approach; however, the PCBM approach would provide much greater

accessibility to high poverty areas (Basu et al., 2017) and be deemed as more practical in addressing a wide array of social determinants of health (Tumber et al., 2019).

Integration of primary and behavioral healthcare in rural, medically underserved, and healthcare provider shortage areas can transform the currently fragmented and inaccessible healthcare infrastructure. Over the years, it has been widely recognized that the physical and mental health are interconnected and cannot be treated separately (Mauer & Druss, 2010). Comorbidity rates of mental health illness and chronic illness, or mental health illness and substance use disorders and their complications have been well documented in the medical literature. However, there is critical shortage in integrated primary and behavioral healthcare facilities for holistic treatment and there is general lack of medical literacy or proper utilization of the healthcare systems from the patients. For example, in Wang et al.'s 2013 analysis, it was indicated that 54% of people with mental health issues were treated in primary healthcare settings (Mauer & Druss, 2010). This data shows no improvement from the Epidemiologic Catchment Area Study of the 1980s, which reported that 50% of mental health treatment was delivered in general medical settings (Regier et al., 1993). IBPH can effectively address such issues of healthcare misutilization or overutilization, and professional mental health counselors are in a unique position to contribute to the integration of primary and behavioral healthcare.

Individuals residing in rural areas, HPSAs, and/or MUAs experience significant disadvantages in access to primary, behavioral, and mental healthcare and resources due to a myriad of geographical, socioeconomical, and sociopolitical challenges. One innovative, cost-effective, and evidence-based solution to increase accessibility and quality of healthcare services is to implement integrated primary and behavioral healthcare services to provide more holistic and collaborative care. Recognizing the importance and benefits of IBPH, advocating for

multifacetedly marginalized individuals, and standardizing interprofessional education in counselor education programs would greatly minimize the health inequality and inequity in the U.S. This study aims to provide a preliminary foundation of achieving health equality and equity via investigating mental health counselors' perceptions and lived experiences regarding their CACREP education on integrated behavioral healthcare in rural, Healthcare Provider Shortage, and Medically Underserved areas.

### **Critical Summary of Literature**

Over the years, living in rural America has been linked to poorer social determinants of health when compared to urban or suburban areas. Rural residents are less likely to have health insurance, less likely to have access to public transportation and healthcare services, more likely to misuse and abuse alcohol and other substances, more likely to visit urgent care for preventable health issues, and more likely to experience suicidality (Anderson et al., 2015). One way to moderate these geographical, socioeconomical, and sociopolitical isolation of rural communities is to integrate behavioral and primary healthcare systems (Lee et al., 2019; Redford, 2019; and Wong et al., 2019). Family physicians account for 10 percent of the total U.S. physician workforce; however, they provide nearly 42 percent of primary healthcare to rural residents in the U.S. (National Rural Health Association, n.d.b). Coleman & Patrick (1976) stressed that the only probably way to provide mental healthcare to all of the U.S. population is to integrate it with primary care. If more rural- and MU-serving primary care facilities are integrated, this would drastically increase the number of rural and underserved patients receiving mental and behavioral health screening, prompt treatment, and follow-up care management. Additionally, with the IBPH, it is strongly projected that less mental health disorders will go undiagnosed and

untreated, and concerns with comorbidities will be more effectively addressed (Gleason et al., 2014).

Although the IBH movement has first started gaining momentum in the 1970s, it is still an underexamined area of counselor education as well as most of other helping professions. Currently, the Council on Social Work Education (CSWE) is the only institutional member of the Interprofessional Education Collaborative (IPEC) Panel that is particularly trained to work with behavioral health concerns, out of 20 IPEC Panel members (IPEC, 2016). Professional mental health counseling is one of the few professions that is well-equipped to effectively address complex human issues, conduct behavioral and mental health screening, and provide behavioral and mental health treatment and follow-ups in IBH settings. Thus, it would be relevant and appropriate to include interprofessional education in counselor education curricula in order to better prepare a competent interprofessional workforce. For professional counseling organizations, it would be critical to actively engage in these interprofessional discussions so that the increasing health inequity and inequality experienced by rural, HPS, and MU populations can be tackled via systemic integration of primary and behavioral healthcare.

Therefore, the researcher proposes to conduct a qualitative research analysis to gain a better understanding of the underexamined areas of counselor education and integrated behavioral healthcare fields. Although the importance of interprofessional education, integrated behavioral healthcare, and social justice and advocacy work for underserved populations has been emphasized in the counseling literature, to date, no study has explored mental health counselors' perceptions on their educational preparedness in serving rural, health professional shortage, medically underserved populations in integrated behavioral settings. A phenomenological approach would allow for a candid, descriptive lived experiences and

perceptions of mental health counselors regarding this topic and further contribute to the development of counselor education and best practices in counseling.

## CHAPTER THREE

### METHODS

In this chapter, the researcher describes the design of the study, instruments used, and data analysis methods.

#### **Conceptual Framework**

The primary purpose of this study is to examine mental health counselors' experiences with and perceptions of CACREP-accredited training needs in working with rural, health professional shortage, and medically underserved areas in integrated behavioral settings. The researcher believes that the data will be richer and impactful with the broad inclusion of rural, HPS, and MU settings for future counselor education and interprofessional education development. Although the importance of interprofessional education and training in counselor education has been recognized for years in the counseling field, there is little to no research regarding the impact of locality or the effectiveness of the counselor education programs in regard to IBH. This study aims to shed light on the future interprofessional competency framework and counselor educational curricula, and to contribute in decreasing the geographical gap in medical and behavioral health services.

#### ***Social Constructivist Paradigm***

Social constructivist view is “a belief system that assumes that “universal truth” cannot exist because there are multiple contextual perspectives and subjective voices that can label truth in scientific pursuit (Hays & Singh, 2011, p. 41).” This post-modernist paradigm is believed to be most appropriate and applicable in constructing this qualitative study as it allows the researcher and the participants to identify contextual diversity in experiences, values, perceptions, frames or references, and intersectionality. It also guides the researcher to focus on

social interactions and their impact on the participants' self-constructed knowledge (Hays & Singh, 2011). As the mental health counselors' employment in integrated behavioral settings is a newly emerging field, a social constructivist approach would appropriately create and provide a space in which mental health counselors can share their raw experiences and perceptions on this underrepresented, understudied topic.

### ***Phenomenological Approach***

Qualitative research allows researchers to explore a phenomenon in the context, through the lens of the research participants (Hays & Singh, 2012). In contrast to quantitative methods, a phenomenological approach allows to depict descriptive experiences of the participants and to offer opportunities to develop meanings of the experiences (Offet-Gartner, 2010). The phenomenological research process helps to find “commonalities across participants to see how lived experiences relate to a phenomenon of interest” (Hays & Singh, 2012, p. 50), which allows for a candid, impartial look at participants' perspectives. This methodology allows the participants' experiences to be preserved and stay authentic (Najmi, 2013; Offet-Gartner, 2010). Based on the literature review, it can be inferred that mental health counselors in integrated behavioral healthcare settings are oftentimes met with difficulties, such as: being expected to assume responsibilities outside their scope of practice, to advocate for the mental health counseling profession to other members of the integrated team, and to navigate the integrated behavioral healthcare system without preparation (Mellin et al., 2011). To date, mental health practitioners' perception of their educational preparation regarding integrated behavioral healthcare or rural/medically underserved communities has not been extensively researched. Therefore, it is appropriate to use a phenomenological approach for the purpose and saliency of the study.

## **Research Questions**

The following overarching research questions were investigated in this dissertation study:

- What are the mental health practitioners' lived experiences in integrated behavioral healthcare settings, serving rural, health professional shortage, and medically underserved areas?
- What are the mental health practitioners' perceptions of their CACREP educational preparation regarding their integrated behavioral healthcare practice in working with rural, health professional shortage, and medically underserved areas?

## **Role of the Researcher**

In qualitative research, it is strongly recommended that the researcher evaluate and bracket their personal values, perceptions, and interests regarding their research topic and population (Creswell, 2013). The researcher is a current Resident in Counseling, a graduate of a CACREP-accredited master's level counseling program, and a current Ph.D. candidate of a CACREP-accredited Counselor Education & Supervision program. The researcher has practiced in integrated behavioral healthcare settings for over two years in various capacities, including inpatient and outpatient mental and behavioral healthcare. The researcher identifies as an insider of the group being studied. Although the researcher assumes no bias that would significantly threaten the integrity of the study, the researcher assumes that the mental health practitioners in IBPH and rural/HPS/MU areas are underprepared from their counseling programs. In order to ensure trustworthiness and bracket potential biases, the researcher intends to keep reflexive journals throughout the duration of research and engage in external auditor debriefing sessions.

## **Participants and Sampling**

### ***Participant Recruitment***

Participants were recruited by using a purposeful, convenience, and snowball sampling method. Once the Old Dominion University's Institutional Review Board approval was obtained, study participation recruitment emails were sent out via professional listservs such as CESNET. Researcher sent out an electronic invitation including an informed consent, purpose and risk/benefits of the study, and the qualification criteria for participation to identified potential participants.

### ***Participant Qualification***

The target sample size was  $N = 8$ . Participants (1) are over the age of 18, (2) have graduated from a CACREP-accredited master's level clinical mental health or couples, marriage, and family counseling program, (3) have clinical experience practicing in an integrated behavioral health care setting (i.e., Level 4 or higher) as a licensed mental health counselor or a resident in counseling in the rural and/or medically underserved communities in the U.S. Researcher used relevant and consistent terminologies that are integral to the purpose of this study, and participants had an opportunity to review these terminologies (i.e., integrated behavioral healthcare, medically underserved areas, etc.) prior to their consent to participate in the study. Specifically, all interested participants were given links to the "Am I Rural?" tool (Rural Health Information Hub, n.d.), HPSA Find (HRSA, 2019), and MUA Find (HRSA, 2019) in which they used to determine if the location of their IBPH practice is in a rural, HPSA, or MUA setting. Participants were also given an opportunity to identify whether their IBPH site meets criteria for Level 4 or higher of collaboration/integration (SAMHSA-HRSA Center for Integrated Health Solutions, n.d.).

## **Procedure**

Prior to data collection, the researcher submitted the study proposal to the Old Dominion University's Institutional Review Board (IRB). Once the IRB approval was obtained, the researcher sent out the invitation via the CESNET listserv, posted the invitation to the study to online forums for counseling professionals, and emailed potential participants who met the inclusion criteria for the study. The invitations included a summary of the study and a consent to participate form (see Appendix A). Participants who qualified for the study and expressed interest in participating in the study were individually contacted by the researcher via university e-mail to schedule interview date and time. All of the interviews were conducted virtually, and all interviews were audio recorded. Interviewees were explained that participation in this study is voluntary and that it is within their right to withdraw from the study at any time without any consequences.

All completed recorded interviews were transcribed by a third-party professional transcription service and reviewed by the interviewees for accuracy and comments. Once the transcription was completed and the participants completed the member checking process, the interview audio files were destroyed. Researcher took reasonable steps to ensure confidentiality and secure storage of the interview transcripts and participant data at all times. Researcher analyzed data and seek an external audit.

### ***Demographic Questionnaire***

Participants were asked to provide general demographic information, including age, gender, and race/ethnicity. Additionally, participants identified their level of counseling education, level of clinical experience (i.e., in residency or licensed), years of clinical experience, types of interprofessional settings worked (e.g., hospital, community clinic,

counseling center), nature of interprofessional settings worked (e.g., primary healthcare based integrated setting, behavioral healthcare based integrated setting, etc.), and expected roles at the said interprofessional setting(s).

### ***Individual Interview***

A semi-structured interview protocol was used to ask focused questions to all participants but also allow room for interviewees to elaborate their views and experiences in a flexible manner. Sample interview questions included: (1) What does it mean to practice as a mental health counselor in an integrated behavioral and primary care setting? (2) What does it mean to practice as a mental health counselor in an IBPH setting, specifically serving rural, healthcare provider shortage, and medically underserved areas? And (3) What aspects or experiences of rural/HPS/MU IBPH practice did you find most salient? A complete individual interview protocol (see Appendix B) included a recruitment protocol, informed consent review, script to participants, and sample interview questions.

### ***Written Materials (Expressive Writing)***

Journaling or expressive writing is commonly used in phenomenological studies as an unobtrusive supplemental data collection method (Hays & Singh, 2012). Participants were asked to keep a journal for a week (e.g., five workdays) and log their thoughts, feelings, and experiences associated with their IBPH practice in rural, HPS, and MU settings. Participants were asked to reflect on the following prompts, including but not limited to: (1) specific educational or training needs or topic areas, (2) specific supervision needs or topic areas, (3) multicultural counseling and supervision issues, (4) professional identity issues, and (5) ethical concerns that they have encountered in rural/HPS/MU IBPH settings (See Appendix C). Participants were asked to return their expressive writing within two weeks of the completion

date of their individual interview. Participant journaling is an effective and unobtrusive alternative to direct participant observation, especially in IBPH settings, which in-person observation would pose a great threat to client/patient confidentiality.

### **Data Analysis**

Once the interviews were completed and recorded, a professional transcription service was utilized. Researcher took reasonable steps to ensure that the data storage and transfer of the audio recording files and transcripts were HIPPA-compliant. Each participant received a copy of their verbatim transcript of their interviews, and all participants had an opportunity to edit, clarify, or retract any statements from their individual interviews. Researcher then used Moustakas' (1994, as cited in Hays & Singh, 2012) modification of van Kaam's Phenomenological Data Analysis to horizontalize and construct descriptions of the data. Mousatakas' modification of van Kaam's Phenomenological Data Analysis procedure is as follows: (1) listening and preliminary grouping, (2) reduction and elimination, (3) clustering and thematizing the invariant constituents, (4) final identification of the invariant constituents and themes by application, (5) construction of an individual textual description, (6) construction of an individual structural description, and (7) construction of a textural-structural description for each interview transcript. Relevant quotes will be identified and grouped, then will be clustered into overarching themes, using the seven steps described above.

### **Researcher Assumptions and Trustworthiness Strategies**

The primary assumption that the researcher holds is that there is a practical gap in CACREP guidelines and practicing integrated behavioral healthcare in rural and medically underserved communities. In order to bracket the assumption and potential biases, the researcher practice the following strategies: (1) utilizing an interview protocol for all interviews, (2) using

member-checking procedure after each interview is transcribed, (3) triangulating the data, and (4) keeping reflexive journal to record thoughts and feelings emerged during the research process. The researcher referred to Hays & Singh (2012) for the criteria and strategies of trustworthiness as well as other peer-reviewed journal articles on credibility and trustworthiness of qualitative research.

Credibility refers to “the truth of the data of the participant views and the interpretation and representation of them by the researcher (Polit & Beck, 2012, as cited in Cope, 2014).” It is critical that the researcher conducting qualitative research adhere by and take reasonable measures to first, “demonstrate engagement, methods of observation, and audit trails (Cope, 2014).” In order to establish credibility as a member of the research participant population, the researcher used reflexive journals throughout the course of this research, asked colleagues for a review of data collection methods, protocols, and analysis, and engaged in peer debriefing sessions.

In order to enhance credibility and trustworthiness of the research, the researcher triangulated the data. Triangulation is “the process of using multiple sources to draw conclusion (Casey & Murphy, 2009, as cited in Cope, 2014).” Researcher conducted individual interviews and unobtrusive observation in order to gain a comprehensive and diverse perspectives of the main research question. With disconfirming data in interviews and journal entries, a negative case analysis was conducted to minimize research bias and strengthen the rigor of the study. During the data analysis process, researcher maintained an audit trail, in which the researcher collected all raw materials and field notes that portrayed researcher’s decision-making processes and measures taken to minimize potential biases. Additionally, researcher invited all interviewees to review the verbatim transcripts of their interviews for member-checking

purposes. They were given one week to review all materials and to report back to the researcher with any questions or comments, and all participants confirmed that the transcripts accurately portrayed their experiences and perceptions.

## CHAPTER FOUR

### RESULTS

This dissertation study explored the lived experiences and educational perceptions of eight mental health clinicians in integrated behavioral healthcare (IBH) settings serving rural, Healthcare Provider Shortage (HPS), and Medically Underserved (MU) communities. A systemic integration of behavioral and primary healthcare has been suggested as an evidence-based and cost-effective approach to healthcare and management (Coleman & Patrick, 1976; Gleason et al., 2014; and Moe et al., 2018). However, the impact of population's locality or the effectiveness of counselor education preparation have not been researched thus far. This study explored eight (8) mental health counseling professionals' lived experiences in integrated settings as well as perceptions of their education and training in order to identify gaps in interprofessional counselor education and analyze healthcare needs in medically underserved communities.

A qualitative approach allowed the research participants to generate rich narratives and thick descriptions on the topics of integrated behavioral healthcare, marginalized and underserved populations, and counselor education and training. Participants were asked to answer ten (10) questions during their semi-structured interview, then to complete an expressive journal entry for a week. After each interview recording was transcribed, all collected data was analyzed based on the Moustakas' 1994 modification of van Kaam's Phenomenological Data Analysis (Hays & Singh, 2012). First, all narratives were grouped based on commonalities of topics that emerged, then the relevant segments were clustered into smaller constituents. Through reflexive interpretation, a process coined by Alvesson & Sköldbberg (2000), the clustered constituents were thematized to accurately capture the textural, structural, and textural-structural

description of the contextual essence of the narratives. Lastly, a negative case analysis was conducted for selected interview with disconfirming data. This process allowed for a more rigorous data analysis and more accurate development of the themes.

All participants of this study were over the age of 18, with the mean age of 28.86 and mode age of 27. Seven participants identified as female and one identified as male. Three participants identified as White, three identified as Black, one identified as Asian, and one participant identified as multiracial. All eight participants have had clinical experience in the areas that were designated as Healthcare Provider Shortage Areas and Medically Underserved Areas. Four participants worked in areas that were classified as rural. The types of IBH settings varied widely, including substance use treatment center, family medicine residency training clinic, free health clinic, private practice, and a municipal mental health facility. The types of IBH settings and their implications are discussed in individual narrative sections in detail.

This study identified five main themes: (1) multitude of therapist roles in IBH, (2) identified benefits of IBH, (3) barriers to integration and MUA care, (4) IBH professional identity development, and (5) educational and clinical training needs. Each theme was coded more categorically in order to generate more specific subthemes. All constructed main themes, subthemes, and their descriptions are illustrated in Appendix D.

### **Christina's Narrative**

Christina has worked in three different types of integrated behavioral healthcare practices in rural, provider shortage, and medically underserved areas. Previously, Christina worked in a family medicine residency training clinic and medication-assisted substance use treatment clinic. During her career at the family medicine residency training clinic, Christina found herself in many different roles as a mental health counselor, providing psychoeducation to both patients

and medical staff, advocating on behalf of individuals in low socioeconomic status with limited resources, and assisting with more effective communication between patients and healthcare providers.

### ***Multitudes of Therapist Roles in IBH***

In all eight interviews, participants congruently identified that they were expected to practice multiple roles in a fluid, flexible manner. Christina's experience in all of her IBH settings described her various roles and responsibilities as a mental health counselor, that are specific to the integration of services and characterized by the clientele she worked with. Christina's narrative is reflective of her unique experience in IBH in which she actively "translated" communications between the physicians and clients to ensure client's accurate understanding of their health concerns and physician instructions.

For low income people, I would kind of go in with a doctor and the doctor would talk with the patient, and then I would almost translate what the doctor was saying in words that the patient could understand. And I would kind of help them figure out what they needed to do to take their doctors' directions. What I found was that a lot of them didn't quite realize that some of what [the doctors] were saying wasn't really translating to clients. [...] There was a patient with diabetes and the doctor told him "you need to be eating vegetables, avoiding simple carbs and sugar." And she asked him what he had been eating all day and he's like, "I eat cereal and milk breakfast, noon and night." And the doctor's like, "well you need to like eat vegetables." And that was kind of that. When I talked to [the patient], I had like another 10 minutes to talk to him, after the doctor left the room, and he's a construction worker who works 12-hour days. And he was like, "I don't have time to do grocery shopping, I don't have time to cook." He's been eating

cereal all day, every day for several years. We talked about how to make those work for him and what it really meant.

In this aforementioned quote, Christina was in a unique position as a mental health counselor in an integrated setting, working with clients with limited resources and medical literacy. Christina explained that whereas most physicians do not have enough time to thoroughly discuss the implications of health concerns and behavioral redirections, she had more built-in facetime with her clients to address these issues. She added that her clinical involvement has been beneficial in bridging the gap between medical professionals and clients.

Seeing the impact that it made, having a mental health trained counselor in the room to bridge that gap and to help them both work together, was just incredible to see. To see the light bulb, to see the doctor trying to explain this thing and then to translate it, and to see the light bulb click for the patient/client, was really powerful and it was something that you don't really get to experience in the regular normal counseling arena.

Another role that Christina identified during the interview was to provide psychoeducation to medical staff. Christina's training in counseling and expertise in working with LGBT+ communities allowed her to share culturally informed practice strategies to medical professionals, whose training may not have emphasized cultural sensitivity. Christina later attributed the multicultural counseling education to her effectiveness and success in serving a diverse clientele in integrated settings.

As a counselor, one of my backgrounds with LGBT clients, so teaching doctors about, "this is how you work with LGBT clients because this is important for you to know because they're not going to come get the help they need" if you're not going to be able to work with them respectfully, or if you're accidentally going to say the wrong thing. So,

helping advocate for my clients in that way where it's like, how to work with these people or how not to assume certain things that they can do when they really can't do...

Christina described one of her many roles as a “problem-solver” in the integrated settings. As most of her clients were individuals in low socioeconomic status, with limited resources and access to healthcare, and in provider shortage or medically underserved areas, her expanded responsibilities included immediate advocacy efforts for access to services (e.g., requesting transportation aid for clients without personal vehicle) and short-term, brief consultations that may not be considered “traditional counseling.”

I get to come in and problem solve and be like, “well, they're not showing up because they don't have any bus passes. Can you guys give them some bus passes, or can we help them figure out a way to get here?” Because that's the actual problem: that they want to come, but they can't.

### ***Identified Benefits of IBH***

Large portions of each interview have been spent on discussing the identified benefits that are specific to integration of healthcare. Christine identified convenience of co-located services, holistic approach to health and wellbeing, and increased professional awareness and development as a result of interdisciplinary collaboration. Systematically integrated and co-located primary, mental, and behavioral healthcare services are found to be convenient for both clients and healthcare providers. Literature also suggests that integrated and co-located services significantly increase accessibility of healthcare and lessen socioeconomic burdens of individuals that are underprivileged and underserved (Suter et al., 2012; Wan et al., 2018).

The idea is to make it as easy as possible to get all these services so they can see their doctor, they can see their case manager, they can see their psychiatrist, they can see their

counselor, and they can get their prescription all in one place, all in the same day. So, they don't have to go back and forth.

Integration also increased a number of patients and clients that could be seen in one setting and streamlined the workflow of primary and behavioral healthcare providers.

For the lack of available primary healthcare or dental health or mental health, I think that makes so much sense that they're trying to tag team to provide health care to as many patients as possible in one setting. It just makes being co-located and integrated makes collaboration so much easier.

Another identified benefit of integrated practices is that it allows healthcare providers to utilize a holistic approach to client care. It allowed the providers from various disciplines to share expertise on all of health concerns, review the health concerns from a diverse, collaborated perspective, and strategically prioritize each treatment to ensure quality and effectiveness of primary and behavioral healthcare.

Approach from a cohesive approach that involved every aspect [...] It was really cool because we could all collaborate on this one person because for example, all of their teeth are bad. That's why they're not eating right. And that's why they're having issues with their body and that's also why their mental health is not great. Being able to work on all of those things together in one place, we could all get a good picture of what's going on.

### ***Barriers to Integration and MUA Care***

In contrast to the myriad of benefits that IBH practice can offer, participants in this study identified unique barriers in serving the rural, Healthcare Provider Shortage, and Medically Underserved populations. Participants unanimously identified adverse impacts of low

socioeconomic status and lack of accessibility to health care as the biggest challenges that they encountered in their practice.

Poor physical health would be making them depressed, but they can't afford their treatments, or they miss their doctor's appointments because they can't catch the bus, or the bus doesn't come near where they live because their public transport system is not great here.

Christina pointed out that many clients who do not have easy access to healthcare simply do not know the type of help they might need. Limited exposure to healthcare or the concept of psychological wellbeing may be a crucial aspect for IBH practitioners to consider when working with rural and medically underserved populations. Additionally, in rural settings, Christina emphasized the importance of being culturally informed while working through the layers of barriers in healthcare access and resources.

They don't have access to care, so they don't necessarily know what kind of help they need. Learning how to ask the right questions or how to give the right prompts, I think is especially important in rural settings. Mental health still has a lot of stigma about it. [...] I think especially with the rural community, they don't necessarily have the exposure that other people have had to the world of mental health.

Christina elaborated further on her experience in working with stigma.

“Don't put that label on me because depressed means I have a mental illness and I don't have a mental illness.” I think I definitely found that happened more often in more rural areas. So, I think overall it's very important to be aware of where they're coming from and their culture.

### *IBH Professional Identity Development*

Overall, participants of this study informed that they engaged in enriched counselor identity development during their career in IBH settings. Christina discussed that it was important for her to navigate the integrated practices with a concrete counselor identity, while being able to adapt it to interprofessional teamwork in a flexible manner.

I think being able to bring counselor culture into the medical culture was good overall for everyone involved. [...] I think it's very important to retain your identity as a counselor, because that's what we're taught is to be soothing, be comforting, be personal and professionally personable. You kind of have to strike a balance between being able to maintain your counselor identity, but also being able to work in this very professional setting that's more formal and still being taken seriously because there are definitely some instances where you might not be taken seriously.

Christina's narratives included that oftentimes she had to advocate for the counseling profession to other medical professionals because there was a myriad of differences in professional cultures.

Doctors can be very focused, like almost extremely solution focused. Counselors are very person-centered overall and we're solution focused on set. I mean we all want to help these people, but I think counselors are taught a little bit more about the person-centered approach and to meet them where they are, and doctors aren't always. I think that is a really big difference in the culture. [...] I was kind of amazed at how much the doctors didn't quite know about the person-centered aspect of working with patients.

She added that she oftentimes felt like she was not taken as seriously as the medical doctors in the setting.

Sometimes I definitely felt like MDs don't necessarily take PhDs or mental health people seriously. It's almost like MDs are in that client's resistance phase. It can be challenging to challenge [MD's] diagnosis, but realistically we spend more time with the clients. [...] Bringing everyone's professional opinions into the room without invalidating anyone else's, can be challenging. Working together can be hard, I guess is what it boils down to. Everyone has to learn how to collaborate, but I think being able to bring counselor culture into the medical culture was good overall for everyone involved.

This difference in professional identities and approaches in client care is also observant in Christine's journal entry. Christine detailed that her clients oftentimes did not feel that they were heard by their physicians and their needs were insufficiently met.

[In practicum] I was at a men's prison. I remember clients coming to me complaining about their doctors, saying their doctors were ignoring their needs. This was my first real experience working with MDs. As I reflect on working in IBH through my career since, I feel like I have noticed a pattern with MDs and counselors not always being on "the same side." Sometimes I felt like I was the only advocate for my client, which was a struggle.

### ***Educational and Clinical Training Needs***

Christina identified that her coursework on multicultural counseling and ethical issues have been most foundational and relevant in preparing to work with medically underserved populations; however, Christina did not have any exposure to integrated behavioral and primary care during her master's program.

I didn't have any exposure to really until I was in the IBH setting. I learned it on the job.

So, I think talking about it more [in counseling programs] because it is a new thing. I

think as counselors we really need to push this, be the advocates for IBH because advocating for IBH is advocating for our clients.

Christina suggested that it would better prepare counseling trainees in master's programs if there was more time dedicated to IBH and interprofessional education.

Knowing that [IBH] is even an option in your master's because I think knowing what to expect, knowing how different the setting is -because it's very different from just, you know, sitting in your cozy office with the couch all day- knowing how to work with other professionals would be helpful. Also I think in some cases, talks about certain licensures or certifications can come in handy.

In her journal entry, Christina suggested the need for an integrated, interprofessional educational opportunity for IBH practitioners. Interprofessional education would not only provide basic training in integrated behavioral healthcare, but also decrease hierarchical power struggle among IBH professionals.

Sometimes I wonder if getting the counselors and medical team in one room together for trainings or even a whole class would be helpful. I feel like even in IBH settings, sometimes there can still be a “divide” between us touchy-feely counselors and the medical doctors/nurses. If there were an IBH class/track offered, I think it could be good to have even just one integrated class, or short series where everyone is a student— hopefully then reducing the divide/power dynamic.

Christina expressed that she believes that having an increased understanding of how exactly IBH can be beneficial to a wide range of clients would be critical.

If we want IBH to really happen, I think counselors need to be the ones to advocate for it and we have to know what it is.

In Christine's journal entry, she discussed in detail that practice-focused education and training is a necessity. Especially in rural settings, financial difficulties are oftentimes a core life stressor that hinders therapeutic growth as well as access to healthcare systems. Christine emphasized the importance and need for IBH practitioners to collectively work to minimize these socioeconomic disadvantages that clients experience.

In reflecting on rural IBH experiences, I think it is important for counselors to have training relevant to the populations they will experience. Often in school, we learn about theories, techniques, and yes, multiculturalism, but that doesn't always look the same in practice. When I first began in a rural setting, I was ready to tackle all sorts of issues related to maladaptive cognitions and behaviors. What I found, though, was that much of my population was low-SES, or were facing financial challenges in general. [...] I think that in the education piece, encouraging counselors to think about more basic needs and how to address those in therapy can be helpful as well as focusing on the self-actualization piece. Helping a client work on problem-solving in a world that is systemically built against them is training that is very needed for young counselors.

### **Kida's Narrative**

Kida is completing her residency in counseling at a medication-assisted substance use treatment clinic in rural, HPS, and MU areas. Kida's clientele consists of individuals in opioid recovery and she emphasized the importance and benefits of integrated behavioral and primary care in treating substance use. Kida also discussed in depth that a number of her clients at the substance use clinic oftentimes do not feel comfortable addressing health issues with their physicians or do not understand their medications. Similar to Christina's experience in IBH settings, Kida described actively utilizing her interpersonal skills and positionality as a mental

health counselor in order to bridge the gap between her clients and physicians and to provide client education.

### ***Multitudes of Therapist Roles in IBH***

Kida described practicing multiple roles as a mental health counselor as well as the importance of counselor flexibility.

[Clients] don't really understand, you know, the medications they're taking or maybe some medical concerns that they're having. It's either because they weren't able to comprehend it from the doctor, there wasn't enough time to explain it, or they just didn't feel like they had the relationship to bring up the concerns with the doctor. And so a lot of times the counselors get stuck with going through that, which again, I don't mind. But we almost get put into the position of having to educate the client on their medical concerns.

Kida's narrative explored her advocacy work in depth. She explained that a number of her clients express medication concerns to her instead of their doctors primarily because of the nature of their relationships. Kida explained that she spends significantly more time with her clients than their physicians do, which oftentimes builds stronger rapport and relationships between Kida and her clients.

A lot of times our clients in group or an individual will express medication concerns to us, and we want to encourage them to talk to the doctor, but they don't always feel supported in doing that. So a lot of times we also have to advocate on behalf of the clients if medication needs to be adjusted. [...] Being able to juggle that role of still working on the mental health concerns, but also advocating for the client for, with their medical concerns as well [is what I find most salient].

Additionally, Kida acknowledged the importance of familiarizing herself with medical literacy and terminology so that she could be most effective in advocating on behalf of her clients with medical concerns. Kida's descriptions regarding counselor-client relationship were congruent with other participants' narratives. Mental health counselors innately spend more time with clients compared to other healthcare providers in IBH, thus, counselors are frequently the ones who can advocate for and communicate client needs and concerns.

I think for me it really falls down to still doing the interpersonal counseling on mental health concerns but taking that one step further and having to be prepared to understand medical terminology. [...] being able to be competent and confident enough to discuss those concerns with the medical professional who should be overseeing that. But as a counselor, oftentimes we get more information.

Another subtheme that emerged in Kida's narrative was practicing increased flexibility within her role as a mental health counselor.

I think another thing too is understanding that like for me, I put up with a little bit more than probably the typical practitioner in terms of not following, um, group rules or treatment guidelines just because we know this might be the only place where they have access to care. And so being a little bit more lenient on it before we discharge and refer out. [...] Like being in a rural area, um, or in an underserved area, the counselor has to take on more hats. Like you maybe won't have as many bachelor's level practitioners or social workers. And so you have to take on the role of gaining resources and making sure that your client has stable, a food source before you can really focus on those deep interpersonal things.

In Kida's journal entry, she detailed a case in which the medical doctor did not take Kida's clinical recommendation into consideration; however, her supervisor supported her argument and Kida felt validated in her IBH work. Kida also mentioned that she had wished that her supervisor proactively introduced Kida's roles and position to other staff members, instead of her "falling into this place." This unique insight hints at additional IBH practice strategy for mental health counselors that counselors in supervisory positions in integrated settings can actively promote the counseling profession, support other counseling professionals, and establish healthy boundaries in practice. Kida also added that since her supervisor has good relationships with the medical professionals in the practice, her suggestions and clinical judgment are valued. It can be inferred that successful and effective relationship building among IBH practitioners can be one of the key elements of interprofessional collaboration.

### ***Identified Benefits of IBH***

Kida noted that she found it convenient and beneficial to have all involved practitioners in the same setting. Similar to many other participants' experiences, Kida described how difficult it was to get in contact with psychiatrists for medication management in non-integrated settings. However, in IBH practices, most practitioners have an increased understanding of the importance of interdisciplinary communication and teamwork in holistic, client-centered care. Kida also touched on basic human needs in addition to health concerns that can be effectively addressed in integrated settings, which resembles a Maslow's Hierarchy.

Like these large CSPs where you have, where you have somebody where the client can see the social workers and get all of those needs met, they can see the counselor to get the interpersonal needs met, and then they can see the psychiatrist to get their medication.

### *Barriers to Integration and MUA Care*

Kida's narrative offered insight regarding the barriers she experienced that are unique to IBH practice for substance use treatment as well as rural group counseling. Kida expounded that a large percentage of her clients who receive referrals to outside providers, there are multiple layers of issues in addition to healthcare provider shortage in the area.

There tends to be a lot of resistance and I don't know if 100% of my clients actually follow through with [external referrals]. I do know a large population don't, and I think most of it is, it's not always just because of the [provider] shortage. I think it's also just the types of clients that we see. We see a lot of Medicaid clients and for them they just don't have the time or resources to get to another provider, whether it's a healthcare provider or a mental health care provider.

Kida was the only practitioner from this study that regularly offered group counseling services. She identified challenges that are common and congruent to group counseling, such as minimizing dual relationships and maintaining confidentiality.

There's going to be a lot of overlap with clients and clients knowing each other, knowing clients from other facilities and maybe having issues with them. There've been times where we have to very consciously assign clients to different groups because their family members, their spouses, or their friends who either do get along really well or don't get along really well. Having those relationships in group hinders the process. [...] I think I find most challenging is working with clients who refused to separate from their spouse when it comes to group. Which happens often. There are a couple pairs of husband and wife who are at our practice and they schedule their groups together. They schedule their doctor's appointments together. And just in terms of effectiveness of care, it's not the

most effective way of seeing and treating them in terms of their addiction. I've also had some counselors here that went to high school with some of the clients that come in and it's just one of those things where you have to separate that and work through it. So, confidentiality is a big one. Being able to manage boundaries and dual relationships is another.

In her journal entry, Kida expressed her struggles with providing appropriate accommodations for her clients with marginalized resources while upholding the rules and standards of her practice. This concern is apparent especially in rural and medically underserved communities where individuals are met with significant life stressors with very scarce resources.

I have a hard time not bending the rules and allowing people into group late when I know they drive over an hour to get here because they don't have a treatment facility near them.

Kida was also the only practitioner whose current IBH practice had focus on substance use treatment. She provided thick descriptions regarding challenges and barriers that are specific to medication-assisted substance use treatment programs. Because her practice served individuals in opioid recovery and prescribed suboxone as part of the treatment, a number of her clients oftentimes expressed raised anxiety or concerns regarding their prescription medication to her. Additionally, the physicians she worked with were frequently met with large caseloads and did not have flexibility or availability in their schedules to meet unexpected changes in client needs.

There's a lot of frustrations that they get due to having such a high load of clients on our practice where maybe they have to wait longer to get in with their doctor, or if something happens where they miss a group or they miss a doctor's appointment, it's not the easiest to reschedule them within the week. And so sometimes they panic because they run out of medications and we just can't get them in because we just don't have the space to do it.

### *IBH Professional Identity Development*

Kida expressed similar concerns and opinions regarding professional identity development and counseling profession advocacy. Kida pointed out that her clinical opinions were not taken as seriously compared to the medical professionals' or other professionals' opinions, even though Kida worked with the clients more regularly and frequently.

I do sometimes run into issues with not being taken as seriously as the counselor or, having my input be hold as much weight as the doctor's, which can be incredibly frustrating because we tend to know more about the clients. [...] But it's not a power struggle. It's more of a, "this is what we do." It's almost like an ignorance thing. [...] I just be like, you know, we have similar training [as LCSWs]. Our training just tends to be more focused on the individual and that relationship. So, I reiterate that we're just as competent if not more.

Kida also offered an intriguing point of view regarding counselor identity development in IBH and suggested that there are clear differences in how different mental health counselors approach integration and embody interprofessionalism.

Some of the counselors that I work with I don't believe are as comfortable with working more professionally with other disciplines at our site. Some of the counselors just come in, run their groups, and then leave. They don't have much interface with doctors or front staff. I don't know if that has anything to do with training or if that's just personality differences.

### ***Educational and Clinical Training Needs***

Kida shared that although IBH was not a formal part of her master's program curriculum, IBH was a familiar concept to her and her classmates because there were many clinical opportunities in the area.

It ended up getting talked about a lot in the curriculum and our classes and a lot of our professors had IBH background. It wasn't a topic that was ever left out. [...] I just think a lot of that had to do with the sites that we have that were approved for practicum and internship. [...] The city that I lived in, there were a lot of IBH settings where you would work on your hours. There weren't a lot of people practicing in private practice.

Kida felt comfortable working with other professionals in medical, legal, and law enforcement fields because she had clinical experiences through practicum/internship, training opportunities through counseling student organization, and early and continuous exposure to interprofessional collaboration in classroom settings. Kida also had experience working with rural and low SES individuals due to the area her school was in, but the specifics of HPSA or MUA designations were not discussed in her curriculum. Lastly, she added in her journal entry that she wished that she had more education and training regarding the roles and responsibilities for professionals in integrated settings.

### **Clare's Narrative**

Clare is a Licensed Professional Clinical Counselor (LPCC) at an integrated behavioral and primary healthcare clinic in HPSA. Clare described her current practice site as being successfully integrated and the integration is embraced by all healthcare providers. Clare routinely and informally collaborates with primary care physicians, psychiatric nurse practitioners, chiropractor, dietician, yoga instructors (restarting yoga classes soon), Licensed

Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), and other LPCCs. Interdisciplinary staff meetings are optional, but there is always one provider from each specialty attending the meetings to discuss client concerns and share ideas. Clare's narrative explored a wide range of benefits that she has encountered in an effective, successful integrated setting.

### ***Multitudes of Therapist Roles in IBH***

Clare's role as a mental health clinician largely echoed other participants' experiences, and her descriptions were reflective of the efficiency and commitment of her integrated site. Clare described "dividing roles" with another health practitioner for a client, so that she can maintain her therapeutic relationship with the client while the other practitioner took charge of psychoeducation.

Sometimes we'll actually divide roles. I have a client right now, a teen boy who is using marijuana. So, the psychiatric NP agreed to kind of be like [inaudible] the person who is more telling him all the facts about the dangers of marijuana use as an adolescent, be more educational. I don't want to say bad cop but be more of that role so that I could stay in relationship with the kiddo.

Clare also described her experiences with resource sharing and interdisciplinary collaboration related to professional development at her site.

We do a lot of resource sharing too. Like "here's a book or an article or a podcast on the topic I liked" and that gets emailed to everybody at the end of the meeting.

### ***Identified Benefits of IBH***

Clare's current practice allowed interdisciplinary collaboration among the most diverse health professionals and her narratives offered very unique insight. Clare's site was also

identified as one of the most systematically integrated sites among the participants of this study and was unique in a way that the practice had the largest number of mental health counselors. One of the most salient benefits that Clare described was that integration and collaboration significantly helped to prevent practitioner burnout.

I do have more autonomy in my new job in the integrated clinic. I want to make sure I give that some credit for no longer feeling burnt out. But I also think being in an integrated setting, even though the demand is still high for our services, I think I am far more, uh, how do I put this? I am doing much better as a clinician. I have a lot less burnout and I feel a lot more like I'm serving my clients from a place of health and wellness myself. I think in some way, even though the demand is still high, like we still have more clients asking for services than we can provide at times, I feel far less burnt out because I think the integrated approach actually helps us practitioners. We are getting support from different colleagues with different perspectives. [...] I think it makes a big difference in my own wellbeing and then my clients benefit directly from that.

In addition, Clare's experience in IBH echoed many of the benefits of IBH identified the literature and interviews from this study. Clare explained that integrated care ensured quality of healthcare as well as thorough follow-ups for her clients. Clare added that a systemic integration fully supported and embraced by the management allowed the practitioners to contribute to each other's learning and growth in meaningful ways. It is expected that different professionals in IBH settings may have differences in opinions regarding client care; however, Clare explained that these disagreements, challenges, and constructive interdisciplinary discussions were always handled respectfully by all IBH practitioners at her site.

There's never any doubt to anyone's credibility, nothing like that. So if there's a disagreement, you're welcome to talk about it if you want. Or you can just choose not to follow their guidance. And that's totally fine too. It's seen as like, "sharing our ideas," but there's a general trust that it's not said explicitly, but we all trust each other to do what's best for our clients.

Lastly, integration allowed for a holistic, client- or family-centered care. Clare described her experience in which she was able to thoroughly explore presented discrepancies of client reports with a psychiatric nurse practitioner. Through interprofessional collaboration and effective communication, Clare and the psychiatric nurse practitioner were able to reach a consensus regarding client care and treatment management.

I have had a couple of disagreements with people I'm sharing a client with, or one of our psychiatric NPs where, when we dug deeper, we realized it's because the mom and the kid are reporting totally different things. To him that things were getting better and everything was fine and all that. But to me, when I saw the kid every week, I was getting a very different story. So that kind of explained our difference in how we conceptualize treatment and recommendations. We've been able to keep our cool, and respectfully disagree and explore the whys and then come to like consensus.

### ***Barriers to Integration and MUA Care***

Clare identified low socioeconomic status as the key barrier to ensuring access to quality holistic healthcare. Clare's practice has recently realized that clients with state-assisted insurance were limited in receiving the full range of integrated care that her practice is offering, outside the basic primary and behavioral healthcare.

I do see that holistic care is definitely limited by income. And our clinic is in the process right now of creating a nonprofit branch so that we can provide yoga, mindfulness, diet [management], chiropractic services, and all of these things to people regardless of income because we do see that our Medicaid and Medicare clients, and our state assistance clients don't use those services so much. [...] I'd say integrated care, at least holistic care, the access seems to be limited by income. So we're trying to work to decrease that disparity of access.

Similar to other participants' narratives regarding commonly experienced challenges in IBH for underserved populations, Clare described that there is oftentimes more demand for physicians from both the client and counselor sides. Clients largely depend on their physicians for prescription and medication management, while mental health counselors also need to consult with the physicians or psychiatric nurse practitioners for medical concerns.

There are professionals that continue to have... There's high demand for them. So that can limit our ability to consult a little bit. I'm thinking specifically of the psychiatric nurse practitioners, there's just so few providers. It's a shortage within the system.

### ***IBH Professional Identity Development***

Clare pointed out that embracing a sense of humility that she is not an expert on every aspect of the client has been one of the keys in developing her IBH counselor identity.

I think the reason I'm so drawn to it is because I think serving in an integrated setting kind of has a sense of humility to it. The idea that I don't know everything and could never know everything that I would need in order to serve clients to the absolute best of my ability. There are so many rich perspectives and strengths that other disciplines have within the field of healthcare that I just don't know yet or have the training in.

Her narratives also reflected her willingness and openness to learn from the different health professions and allow differences in professional opinions to serve as a learning experience for herself.

If anything, that challenge will just lead me to reflect deeper on, “well, why is it that I'm inclined to do it the way I'm inclined to do it” and to get me to reflect on it more. I think as a whole it ends up being, while challenging at times, ends up paying off.

Another salient part of her IBH counselor identity was to acknowledge the benefits of integrated practices and to advocate for a greater IBH development in the medical and counseling fields.

Being in integrated setting, like it's hard to imagine ever wanting to not be. That's awesome and so much better. [...] I really hope that other clinicians or other clinics are moving in this direction, if they, find that this is also a fit for them.

### ***Educational and Clinical Training Needs***

Clare discussed that while her educational and clinical training during her master's program prepared her to develop a strong counselor identity and work effectively with underprivileged and underserved populations through systemic perspectives, there was not a lot of focus on interdisciplinary work.

[Name of the institution] doesn't have a med school, so that's a little limiting, or social work program or any of those other specialties. But it would've been great to have contacts with students or professionals from other disciplines, like brought in as guest speakers or more context provided on what other perspectives or approaches might look like in integrated settings. [...] Even some instruction in grad school about roles of social workers, the person who will have the resources most likely on-hand.

### **Imani's Narrative**

Imani has been practicing at an integrated counseling agency for the past two years and has recently completed her Residency in Counseling at the same practice. Imani described that she mostly works with low-income individuals and families and Medicaid clients in the HPSA- and MUA-designated counties. Imani has been providing between 25 and 30 sessions per week and keeps a caseload of 45 to 50 individuals or families on average. Imani noted during the interview that she is passionate about serving medically underserved communities and increasing access to healthcare for all, and that IBH is an effective approach in achieving those goals. She also added that IBH practice in HPSA and MUA has positively influenced her professional identity development. Themes that have emerged from Imani's narrative were congruent with the rest of the interviews.

### ***Multitudes of Therapist Roles in IBH***

Imani described collaborating with other healthcare providers at her practice to provide psychoeducation on basic health maintenance and health behaviors as part of their practice.

[We] have, encouraged individuals to get medical workup or have them yearly physicals, whereas usually they wouldn't. If you make it a condition [inaudible] you're more likely to go.

She added that a lot of her clients had not established continuous care with a primary care physician, or had not seen a doctor in several years, so in addition to providing traditional individual and family counseling services, she engaged in basic health and psychoeducation. Similar to other participants' experience, Imani echoed that she was usually able to establish better rapport with her clients because she met with them more regularly and frequently compared to other healthcare providers at her practice. Building rapport and maintaining

therapeutic relationships with clients also made it easier for her to advocate on behalf of her clients and led to an increased level of service integration.

They're meeting with me more often than maybe meeting with [psychiatric nurse practitioner]. I get to see them more often. We have usually a better relationship. [...] I have had the opportunity to sit in on [the psychiatric nurse practitioner's] session with the client, to advocate when they have difficulty representing themselves for whatever reason, they just would rather have me in the room. I think that's an educational opportunity too because all three of us would sit down together, and it's like "Whoa, this really pays off." We're all sitting in, all three of us, solving a problem and that's a nice, it's the most effective.

### ***Identified Benefits of IBH***

Imani agreed that interprofessional collaboration has been beneficial in client care, specifically for clients with higher and more complex healthcare needs. As she is mostly working with individuals with low income and limited resources (e.g., personal transportation), Imani finds it very helpful to have all practitioners in the same building to minimize travel time and loss of potential earnings for their clients. In addition to increased accessibility to diverse healthcare services, Imani explained that the integration system leads to more training and educational opportunities for the practitioners that are relevant to holistic client care.

We have a lot of trainings at the agency that I work at, kind of like the operational manuals. [inaudible] see what medications would look like, what questions could be asked, and what might be some insightful areas to ask the psychiatrists about. And the same for that was if they have questions about compliance or counseling concerns, they can also collaborate with us.

Imani pointed out that her practice has been eagerly working on improving the integration of the behavioral and primary healthcare services. Even though there is a PCP to client as well as mental health counselor to client ratios set in place, Imani noted that the practice has been experiencing shortages in primary healthcare providers. The setting was not optimal for the PCPs to become active initiators of interdisciplinary collaboration due to their caseload; however, Imani added that the PCPs offered critical insight and assistance with medication management when requested by the mental health counselors.

They're helping me understand the possible side effects for the medication or potential ways to support mobility, and things that I didn't have more insight on before.

Conversations with [PCPs and psychiatric nurse practitioners] have allowed me to have more insight and awareness of how some of the factors that impact the client's daily wellbeing [...] It's been really helpful having those practitioners around, particularly to collaborate on the care of individuals.

### ***Barriers to Integration and MUA Care***

Imani detailed her experiences and perceptions regarding the challenges that low income, medically underserved clients share with her. She specifically pointed out the disturbing reality that many underprivileged clients miss out on free resources and healthcare because of complex life circumstances such as unreliable transportation system or limited time-off from work.

What really stands out to me is there's a really big polarized differences in resources that individuals that come and do the work and are so grateful, and those who, because of their life circumstances, literally may not be in position to be... There are people who live in this environment that have a really hard time getting connected with healthcare, specifically behavioral healthcare. [...] It's hard because although it's a free resource here

waiting for you, and I want to continue serving you, it's impossible to wait for months and months if you are unable to come.

Additionally, Imani agreed that the PCP's and psychiatric nurse practitioner's large caseload prevents in-depth interdisciplinary collaboration or consultations.

I will say oftentimes that they are booked and busy with back-to-back clients. For instance, like an active psychiatric nurse practitioner may see at least 15 people a day. Squeezing in to talk or collaborating with her can be difficult.

Imani informed the researcher the day after her interview, that the psychiatric nurse practitioner at her site had quit her job due to the continued heavy caseload and lack of support in balancing her workload by the management. In her journal entry, she expressed her concerns regarding her own caseload as well. This narrative adds depth in the Healthcare Provider Shortage Area and Medically Underserved Area literature, that these underserved areas have a systemic problem that posits additional burden to practitioners. Imani explained that an average caseload quota for mental health counselors at her practice is significantly higher than the average caseload in other settings (e.g., private practice) because frequent no-shows or cancellations are expected and assumed in medically underserved communities.

Sometimes I'm so overwhelmed working here (because of quota expectations and numerous administrative obligations) that I consider to myself... Am I sacrificing my own mental wellbeing for the sake of others? The unfortunate truth is many days the answer is yes, and even though we were told over and over in our grad program that's not how it's supposed to be, it's a sad reality for me and many of my colleagues and fellow alumni as well. Does a world exist where healthcare systems can be accessible to all those who need it, without that system being built at the expense of those trying to serve?

Burnout is real. Vicarious Trauma is real. And no one talks to you about that after you graduate, which is why I have considered working at Target instead of working for a profession that often doesn't work for me.

This narrative is unlike Clare's experience in IBH, in which Clare felt more supported by collaborating with other professionals and in turn felt less burnt out. This variance introduces meaningful dialogue in counselor education and interprofessional education, and provides further support for a higher level of systemic integration of behavioral and primary care services for underserved communities.

### ***IBH Professional Identity Development***

Imani's IBH counselor identity development centered around her advocacy work regarding increasing accessibility of mental health counseling to a larger population.

[IBH] is really important to me. I think that's why I got into it because I didn't feel like there were enough accessibility offerings for individuals with low SES. I'm really passionate about therapy being accessible to everyone and anytime. IBH allows behavioral health to be accessible to more people. So, it's a big part of how I see myself professionally. [...] It's really important for me to be in an agency that has support for individuals, maybe with or without mobility, or low income, or whoever.

Her strong counselor identity and commitment to social justice and advocacy were represented in her journal entry as well.

Social justice and multi-cultural counseling are nearly always on my mind in this setting. Not a day goes by where I am not reminded of how systemic injustice is swarming around my case load just because of their ethnicity, or how much money they make, or because they have

different abilities than the average person. I'm glad we exist so that there is slightly more accessible services, but I'm positive that more could be done.

### ***Educational and Clinical Training Needs***

Imani elaborated that her master's program prepared her to become a competent mental health counselor and work with underserved populations through educational and clinical training; however there was no education or training in interprofessional collaboration with medical field.

I think [educational curriculum] prepared me professionally as a counselor, and I can speak a little bit more for that, but I don't remember there being any education or insight or trainings on collaboration with medical professionals. [...] From what I remember, both my practicum and internship focused on medically underserved populations, just because of the nature of their location. I know that our internship was completely free and student-run. So, understanding that some of the types of social stressors that come with individuals in those communities was good. It was helpful for me to know that before I used to work on my own.

Imani advocated for the heavier emphasis on substance use, commonly prescribed medications, and chronic illnesses in the diagnostic coursework, as substance recovery and medication management can be a bulk of IBH caseload.

For instance, like fetal alcohol syndrome or fibromyalgia, that could really influence and impact individuals' mental health, and there wasn't anything I read about. I've gotten a lot of education about these from our psychiatric nurse practitioner, about ways that I can better help people and treatment or therapy perspectives. But it wasn't even a thing I knew about them before.

She also added in her journal entry that she wished to receive more training in ways to address comorbid illnesses and evidence-based counseling techniques and their usage in treating specific physical health conditions.

I could probably use more training in ways to address clients with co-morbid physical illness. For example, is it okay to use progressive muscle relaxation with someone who has chronic pain? or is there adapted deep breathing for individuals with asthma?

### **Nadine's Narrative**

Nadine is working as a Resident in Counseling and has worked in two different settings that required interprofessional collaboration. She previously worked as an intensive in-home therapist for Medicaid families. She explained that because the in-home services were funded by Medicaid, there was a mandatory cooperation and collaboration between various providers for the families, including psychiatrists, teachers, school counselors, social workers, case managers, and mental health counselors. Whereas her in-home required external interdisciplinary collaboration, her current position is fully integrated in-house. Currently, she coordinates services for children and adolescents in need of holistic care while working closely with outpatient services, medication management services, case management services, and other aspects of client health and wellbeing that are deemed necessary. Nadine also has an option to provide short-term crisis management counseling to her clients when necessary. Nadine explains that the biggest difference between her two IBH practices is that the co-located integration allows for increased support, efficiency, and efficacy of all services rendered.

### ***Multitudes of Therapist Roles in IBH***

Nadine noted the salient differences between working in integrated settings and working in private counseling practice.

I think in an integrated setting, even if you are a counselor, I think your role is still a little more, it's still kind of multiple roles versus at a private practice... Private practice is more just focused on providing therapy and talking with [clients], and there's so much more in integrated settings that we have to do. [...] You're a case manager or sometimes you're a family therapist. It just kind of, you have multiple roles, I think. I think that also has to do more with the community.

Nadine also shared her experiences in engaging in interprofessional treatment planning, in which she oftentimes noticed differences in opinions regarding prioritizing the client needs. Nadine's identified role included sharing her clinical opinion on mental health concerns with other healthcare providers and collaboratively developing the client's treatment plan that would holistically benefit the client.

### ***Identified Benefits of IBH***

Nadine emphasized the convenience of integrated and co-located services. She pointed out that sharing medical and other relevant records in an IBH setting has greatly reduced practitioner workload. Nadine reiterated that the interprofessional collaboration is productive, beneficial, and necessary, especially for individuals and families that may be experiencing various life stressors and psychosocial challenges. She described that the team approach as "having years of experience combined together" that helps the practitioners and the clients see a wider picture of the presenting issues and diverse possibilities to tackle those issues.

I think that going from a setting where I had to reach out individually to individual practices versus now, where everything can be done in one day, I think it feels a lot more beneficial to us and clients that may be struggling financially. We can support transportation, it's really positive to be able to say "you can get everything done in one

place,” and not have families all up and down the road everywhere. [...] I think it's a necessity really. When I was working with families that are in more of those environments, there's not really many places for them to go. [...] I think hearing that [we can holistically support] is really reassuring.

Similar to other participants' experiences, Nadine spoke about the collaboration being most effective and straightforward when all involved practitioners are committed and consider the collaboration as part of their normal procedure.

### ***Barriers to Integration and MUA Care***

Nadine described her experience regarding difficulties with connecting with psychiatrists or other medical professionals. She identified having different styles of professional communication and limited time in their workload as the key barriers.

Different professionals have different styles of communication, let's say. So it was easier for me to get a case manager on the phone, then it gets difficult to get a psychiatrist on the phone. It became a little upsetting. I even had a couple of supervisors that were like, “yeah, the chances of you calling, getting a call back with psychiatry are, are very small.” That was interesting to me because I didn't know that there was a discrepancy like that I guess. But it makes sense. I mean they're seeing a lot of clients but it also could be frustrating.

### ***IBH Professional Identity Development***

Nadine expressed that she realized it is critical to be open to and be proactive with reaching out to professionals. Her IBH counselor identity focused on practicing open communication with team members and initiating interprofessional collaborations for better client care.

I think just being open. So, keeping an open communication and not being afraid to admit things to others, like I'm working with someone and they're stalled a little bit. Not being afraid to reach out to the other service providers and say, "hey, have you noticed anything?" or "this is where we're at. Do you have any insight that you think might be helpful?"

### ***Educational and Clinical Training Needs***

Nadine described that she was expected to collaborate with school counselors when she was completing her internship as a family counseling student. Nadine advocated for a more comprehensive education and training on interprofessional collaboration with various specialties that counselors may be expected to work with in the future.

I think more insight into what would that collaboration look like with other professionals in this deal, especially like dealing with probation officers, that was an entirely new for me.

Nadine shared that she wished that she learned more about what it meant to be a professional counselor outside the private practice setting. She did not recall having discussions regarding integrated services in her master's program, but believed it would be important to have exposure to the field.

I obviously think [IBH] is an important topic, but at the same time I didn't know about this until after I actually started doing my residency in this setting. So, there should be more awareness about [IBH] in a counselor education program for sure.

### **Jen's Narrative**

Jen described her overall IBH experience as greatly positive, beneficial, and rewarding. Jen is a Licensed Professional Counselor and working at a family medicine residency training

practice as a behavioral health counselor. Jen works closely with family medicine physicians, other medical healthcare providers, and a clinic consultant to serve individuals from rural communities, low-income individuals, and immigrants who are not U.S. citizens. Jen's noted that her practice is effectively integrated, and the IBH model has been positively regarded by all healthcare providers and the patients.

### ***Multitudes of Therapist Roles in IBH***

Jen's primary responsibility at her practice is to provide mental health and behavioral health counseling services. She noted that oftentimes she would receive referrals from the physicians for patients exhibiting symptoms of depression or anxiety during their primary care visits, or for patients whose health behaviors are seriously impacting their physical health.

Kind of anything that could be seen as a potential behavioral health concern. So, if they have hypertension, I'm really look working on like breathing techniques, mindfulness, things like that. And those are more for clients who aren't really wanting to get into counseling but more just like how to, how your behavioral health has the impact on your physical health. [...] It's been a really good experience. Um, something that I've never really, I think done before. Um, having to collaborate with the doctors. Um, we also have dental included as well. Um, and so I think it's kind of cool to see clients when they come in for medical appointments who are experiencing a lot of symptoms of anxiety or depression or trauma, um, and be able to kind of talk with them firsthand.

Jen added that she works closely with a consultant who is also a Licensed Professional Counselor. The consultant's role at the clinic is to provide behavioral consultation to medical staff, immediate assistance to physicians in times of crisis or escalation, as well as brief behavior-focused psychoeducation during primary care visits.

We do have a consultant who actually works really closely with the doctors, um, to help deescalate or kind of just give some overall wellness tips. Um, and then for, um, clients who maybe are a little bit have more intensive symptoms or who are really more interested in counseling. [...] She's an LPC as well. And her training is more, um, with kind of, um, I guess working more with a lot of like anxiety, depression, um, a lot of motivational interviewing for diabetes, for smoking, um, weight loss.

Jen portrayed that although Jen and the consultant are both LPCs, their primary clinical responsibilities are clearly distinctive, and their services are utilized differently. Oftentimes though, Jen finds herself assuming more than one role as a behavioral health counselor and stepping in to assist in immediate behavioral health consultation when needed.

If we have a client, if the doctors have clients who are in really big distress and they just really need to talk to someone and whether the consultant doesn't have, um, time where she's in another room, they'll usually pull one of the counselors out and try to help deescalate the clients. Um, especially if there's any type of like, um, assault or trauma that's kind of coming up with some of just like their routine exams.

### ***Identified Benefits of IBH***

One of the most frequently discussed benefits of IBH from the interviews was medication management. All participants agreed that they (i.e., mental health counselors) were oftentimes the first to notice the impact of changes in medication, or the first to be notified by the clients because they met with their clients more regularly and often, compared to other healthcare providers. Jen echoed that being able to approach physicians regarding medication effects and management was a huge benefit of working in IBH.

For the most part it's been really helpful to be able to talk to the docs about some of the medication that our clients are on, some of the symptoms that they're experiencing, or if their medication is not working. The doctors usually do a good job at trying to get them in faster.

Similar to Clare's experience with shared responsibilities in client care, Jen reported that her team had an increased appreciation and awareness regarding flexibility in assuming roles and responsibilities, and the practitioners were dedicated and willing to provide different types of psychoeducation services based on their relationships with their patients.

We all try to give a little [psychoeducation] It's probably coming from the docs a lot if they're here for like a routine healthcare check or a medication check. We do have RNs on staff who do give a lot of information or some of the MAs do. Sometimes it's our consultant who's trying to give some information if the client just really came in for a quick check. If they didn't want to spend a lot of times with the doctors, then the counselors will do it. It really just depends on the relationship between the client and the provider and who they're most comfortable with, and who they spend the most time with.

Jen described that the teamwork approach was effective in showing their patients that the providers do care about their overall health and wellbeing, and in turn, the patients felt raised ownership regarding their progress. Jen's interview offered some unique insight on rural, HPS, and MU communities as well. Jen identified that her practice administrators and care providers were committed to providing health services to underserved population and making patients' medical experience enjoyable. Systemic support and efforts allowed healthy work environment for the care providers and led to efficiency in workflow.

It's been a really good experience because I think you get to see clients come in and have support in all aspects. A lot of the times, getting to the clinic is challenging in itself. And so the fact that we have medical here where they can get all of their medical needs met, and same day have a behavioral health appointment. I think it makes follow-through really more consistent if they can get all of their appointments done at one time and to have a system that actually allows and supports that.

Lastly, Jen added that patients who received integrated care often made faster progress compared to patients who opted out of IBH.

We see those clients that we've helped with the collaboration and fully surrounding them with services and seeing how fast they progress, versus, we see patients just come in to get medication and then maybe follow up with behavioral health once or twice, and they maybe do not make as fast of a progress.

### ***Barriers to Integration and MUA Care***

Jen identified that although her practice is fully integrated and all professionals are committed to provide comprehensive physical and behavioral healthcare, she still experiences barriers, including lack of available resources, lack of consistency in keeping appointments, and lack of medical literacy for the clientele she works with.

I think the biggest challenge that I always run into is resources and consistency in appointments. I have a couple clients who come in that are super enthusiastic about counseling and then, they kind of tend to stop the participation because, for example, they live all the way out in Apache junction, which is probably 30, 40, 50 minutes from the clinic depending on traffic and access to transportation is limited. They can't always get

to their appointments on time. [...] Also, a lot of our clients, they may not have the diagnosis, but there's a lot of forgetting their appointments or to follow through. [...]

The lack of knowledge that most of them come in with... Not seeing, not understanding why physicals every year is important.

She provided a thick description on her clinical work in a rural IBH setting as well. She realized that some of her rural patients encountered very unique environmental challenges as well as were coming from a very different cultural system.

With a rural population, it's just been eye-opening, realizing the bigger environmental challenges that they've had. And all of the family systems or cultural concerns have to be taken into consideration when working with some of the rural underserved population.

And usually it's a very big transition from working in private practice where a lot of that is kind of very structured, very set, and very consistent where here's a lot of inconsistency with the underserved rural population.

### ***IBH Professional Identity Development***

Jen's IBH counselor identity centered around actively promoting the benefits of integrated, holistic healthcare approaches as well as engaging in provider outreach to medically underserved patients to achieve patient buy-in in IBH services.

Both medical and behavioral clinicians do really enjoy serving the underserved population. Usually, having a good attitude at work making the environment and their medical experience enjoyable has also been a big help. [...] Provider outreach has been the most important work for showing the clients, the clientele that the providers do care. And a thorough follow-through. I think the outreach has been really helpful as far as building that really good rapport to try and get them in on a more consistent basis.

### ***Educational and Clinical Training Needs***

Jen identified basic counseling skills as the foundation of her level of preparedness in IBH settings as well as working with underserved populations.

I think the only way that they really helped prepare me was practicing empathy. And, those really basic counseling skills of being empathetic, providing unconditional positive regard, and active listening.

Integration of primary and behavioral healthcare services or the connection between physical health and psychological wellbeing were not included in Jen's master's program curricula.

It really feels like there wasn't a lot of preparation. Going through the program, I don't really remember a lot of learning about anything medical or the importance of connecting mental health and physical health together. [...] We talked a lot about symptoms, so, when you look at anxiety, common things for anxiety is stress, muscle tension, and things like that, but nothing was really elaborated on. And so really understanding how closely correlated physical health and mental health are would be helpful.

Additionally Jen expressed that more robust multicultural counseling education and practical application of counseling theories would be beneficial in preparing counseling trainees to practice in IBH settings, serving a wide range of populations.

### **Adrian's Narrative**

Adrian previously worked in a free IBH clinic serving rural, HPSA, and MUA clientele as a Resident in Counseling. His main responsibilities included providing traditional individual counseling services, collaborating with other mental health professionals (i.e., Licensed Professional Counselor and Licensed Clinical Psychologist) as well as primary healthcare providers, and providing basic psychoeducation. Adrian described that although the integration

of services greatly helped to increase healthcare access for underserved populations, integration was not actively supported or practiced by all healthcare providers at the site. Adrian described that mental health professionals were eager to initiate interdisciplinary collaboration with primary care physicians specifically on the issues of substance use, medication management, and chronic health issues; however, the collaboration was not reciprocated by the medical professionals.

### ***Multitudes of Therapist Roles in IBH***

In addition to providing individual counseling services, a large part of Adrian's identified role was to offer mental health competence and to contribute to interprofessional learning and development.

It means that I am joining a team of providers who have a variety of expertise and my expertise is in providing counseling service. That's my area of competence that I offer to the clients that I'd be working with. And also, that knowledge that I'd be sharing with others that I'm working with [...] and be someone who's offering mental health competence amongst other professionals and being receptive to different professionals' opinions.

Although Adrian's narrative reflected that he was not as supported by the integration of services at his site compared to other participants, the multitude of identified roles as an IBH counselor was congruent.

To dispel some myths about what counseling is, if cultural beliefs were to come up. [...] Another role or function that I had was to actually be an advocate for our clients. For example, I worked with a client who had some memory issue. For me that's not an area of specialty and I can say, "Hey, this person has a memory issue," without doing something

like testing that I am not qualified to do. So what I would have to do is try to look out in the community to collaborate or speak with my supervisor to see how I can help this person get services that have an impact or are related to their mental health. Because that isn't something that I can specifically, diagnose or treat myself.

Lastly, Adrian emphasized the ability to practice flexibility and adapt to meet various types of needs that clients bring in.

Being open, curious, and flexible with them. I'm not taking this one cookie-cutter type of approach to counseling, but I'm adapting it to meet other people's needs.

### ***Identified Benefits of IBH***

In Adrian's narrative, providing holistic care to individuals has been identified as one of the benefits of IBH. He added that there was interprofessional learning among the team that he worked with.

I found working together with and providing holistic care to the clients that we're working with to be helpful. [...] There is a lot of contributing to and learning from others while providing a service to clients.

### ***Barriers to Integration and MUA Care***

Adrian's narrative largely differed from the rest of the interviews and journal entries and represented ideas that differed from the general advantages and barriers of IBH practice in this study. Adrian focused on the consequences of decreased site commitment to integration of care and criticized its ripple effect on the daily experiences of a mental health counselor. His unique observation and thick descriptions of his clinical experiences led to a negative case analysis, which eventually allowed for development of a more robust, accurate, and expansive theme: Barriers to integration and MUA care. Adrian was the only clinician in the study whose site

operated as a free clinic, mostly staffed by volunteers and student interns. Although his site was integrated, there was a lack of cohesiveness and administrative commitment in providing holistic services as an interdisciplinary team. This key acumen supported existing literature which suggests that the levels of integration and site commitment at the organizational level are an essential element in successful IBH practice, while reiterating that the integration is not a sole responsibility of practicing clinicians. In fact, his thick description portrayed that inadequately supported IBH may result in additional strain for the practitioners. This negative case analysis strengthened the rigor of this study by minimizing potential researcher bias and refining existing ideas.

Adrian identified many of the universally discussed barriers in IBH care for underserved populations, as well as specific challenges that he encountered at the site where integration practice was not effectively streamlined. He described that a number of depressive symptoms and suicidal ideation cases seemed to be related to or seemed more prevalent in low income individuals.

I guess was from a mental perspective, working a lot with depression and suicidal ideation or suicide attempts compared to other settings, [those symptoms] were really prevalent. Particularly it seemed like it was related to low income [...]. Coming from a larger town, it was a bit of a shock to see the extent that poverty had impacted many of the clients that I was working with. I think that the general attitude of humility that I have picked up and been developing from multicultural counseling courses was helpful in being able to understand the nuance that existed between living in a rural area with limited access to healthcare and experiencing mental illness.

Adverse impact of poverty in accessing healthcare is also apparent in Adrian's journal entry. He discussed that issues of poverty, employment/unemployment, and limited resources and access based on geographical locations played a major role in his work.

One difference that I noticed was the applicability and transferability of career counseling as it was taught to me. In working with clients that lived in rural areas and in poverty, many of the ideas of workplace preferences, personality, and taking a developmental approach to career development that I learned in my master's program seemed like a privileged approach to integrating career counseling into my work. It seemed that it was more often the case that a lot of employment issues centered on maintaining a job to cover essential family needs in spite of poor working conditions, physical health ailments, and disability. This is one area that I am realizing that I felt underprepared to work in.

Furthermore, Adrian provided a rich narrative on the negative impact that lack of communication at his practice created. He later added in his journal entry that lack of or minimal communication between professionals in a setting that is intended to be integrated could result in harm or unintentional neglect in client care.

Consequences of things not being completely integrated. [...] I guess one thing that I found really challenging was the lack of communication piece. I didn't really know when my clients were coming or how they were scheduled. That was handled by someone else since a lot of the clients were primarily coming for some medical concerns. I mean that made it difficult to prepare, or sometimes I might prepare and then the client would cancel because they did not want counseling. [...] One instance, I had a client who had suicidal ideations and for me they were at risk, but they dropped out of the mental health

service. They continued to see their physician or another provider and a couple of weeks later when they picked the counseling back up, I was informed by the client that they had actually made a suicide attempt. And that was the first time I had heard of it. That lack of communication for me was a challenge. It gave me anxiety, like, “Oh, I could be liable.” But I'm simply unaware because it wasn't documented by the other professional or I just wasn't informed about it.

Adrian alerted that lack of understanding among professional identities and scope of practice could result in insufficient client care in integrated settings. In his journal entry, he shared that there were times he received internal referrals that seemed less than appropriate, due to lack of understanding in professional roles and identities at his practice.

At times, it felt as if some of the clients that were referred to me could have been referred to other professionals within the agency that had greater expertise in certain areas than I did. For example, one client that I began working with needed assistance with paperwork related to disability and benefits and navigating issues that came with that. It seemed that referring the client, who also experienced a history of trauma and mental illness, to only me and not the social workers that also volunteered was a disservice in that instance. It also made me wonder about times in which mental health issues may have come up when receiving medical care from the medical professionals but went unrecognized.

Adrian was the only practitioner that pointed out lack of funding as a key barrier in IBH care for underserved populations. Specifically, he described his experience in which he had difficulties finding appropriate translation services for clients who did not speak English or Spanish fluently due to limited resources and lack of funding to acquire better resources. He further included in his journal entry that his practice was a free clinic that was predominantly staffed by volunteers

and student interns, and called for a need for better substance treatment care and trauma-informed care for medically underserved population.

It seemed like funding was another challenge. I'm thinking specifically with working with a lot of clients who didn't speak English as a first language. If they spoke Spanish, it seemed like I could find someone else to translate, but not for other languages.

### ***IBH Professional Identity Development***

Adrian identified flexibility and adaptability as key factors in his professional identity development, especially when working with individuals from rural or medically underserved communities.

What I learned was that how I had previously been taught to do counseling might need to be adapted and shifted to meet the needs of the clients I was working with. Even though [name of the city] isn't a rural area, a lot of the clients that I was seeing were coming from areas outside of here, which is a bit more rural. So, many of them came from a low SES background and some of them had never been to therapy or seen a counselor before.

Adrian also noted that although the medical professionals were not as dedicated as systemic integration of the services, he found it important to advocate for his counselor identity and to provide training or awareness activities for other professionals.

Looking back at the experience, I don't feel like I learned a lot about the medical aspect of what the different providers were doing. I helped with a couple of different training or awareness type of activities.

### ***Educational and Clinical Training Needs***

Adrian identified coursework on multicultural counseling ethical issues, and substance use and treatment as most beneficial in preparing him as a mental health counselor.

I guess multicultural classes, they seem like they were helpful in emphasizing an attitude of humility and curiosity. [...] I guess a set of classes I feel like helped prepare were substance abuse classes, particularly because they mentioned distinctions between different models of looking at addiction, like the medical model. [...] For ethics courses, the emphasis placed on consult with other people and when you're starting to feel like you're going out of your area of competence, consult with a supervisor or bring up issues in supervision. I feel like those messages were pretty consistent and clear and were applicable.

Adrian called for a more comprehensive educational preparation on psychopharmacology and interprofessional collaboration with various specialties. Additionally, Adrian discussed that while his education and training in multicultural counseling was invaluable and timely in IBH practice for rural and medically underserved communities, he questioned what type of multicultural training other professionals would receive in their career. As counselor education strongly embodies and prioritizes multicultural practice and cultural humility, providing interprofessional support and education for IBH practitioners in culturally informed care may be another direction that mental health counselors could launch.

Cultural differences seemed ingrained in every aspect of the agency. From clients speaking various languages and needing translators, working in counseling sessions with a third person, and differing worldviews to presenting problems, this setting required an active willingness to engage in interfacing with different cultures. While I have some amount of training and comfort in learning from and about others that are different from me, I was curious what the training experiences of the medical professionals were.

### **Kristyn's Narrative**

Kristyn has experience in working at a federally qualified health center (FQHC), which was part of the HRSA-SAMHSA behavioral health workforce grant. Her position was newly created by the clinic when she joined the practice as a behavioral health counselor. She actively collaborated with primary care physicians and provided short-term on-site assistance and handoffs in addition to providing long-term traditional individual counseling services for patients. As part of the grant program, the PCPs participated in administering annual mental health risk screenings for all of their patients and referred patients who scored positively on the risk screenings to Kristyn for further assessments and care. Additionally, Kristyn worked with patients that presented mental health concerns during their primary care visits.

### ***Multitudes of Therapist Roles in IBH***

Kristyn's clinical experience as a behavioral health counselor mirrored other narratives in a way that she balanced multiple roles in the clinic. Her position required a great level of flexibility and on-the-move, prompt transitions in between the different responsibilities to accommodate the nature of the family medicine training clinic. Kristyn described that sources of patient referrals were also varied depending on the case.

If a provider needed me and it was not for that screening, they usually would just walk up to me and say, "hey, I've got this person in my office. They've been dealing with anxiety, they're interested in medication, but I was hoping you could talk to them too or whatever the presenting problem was." [...] So most of my referrals, usually they came from the screening and then sometimes they came because an individual presented to the primary care physician with mental health concerns.

Kristyn noted that there was another LPC on site, but their responsibilities were different at her site. Her narrative provided keen insight on various ways that professional mental health counselors may be involved in primary care practices.

There was another LPC. He had been there for years and they knew him. They would refer people to him too, but he was never really down on a medical floor. The only time that happened was if they had a suicidal patient that came in, and they would call him down for help with that. He was in the building but not necessarily a part of that integrated care team piece. But he was always there too, which was nice if I needed a consult about something [...]. He was good to collaborate on certain things if I had questions. But for the most part, um, our jobs were pretty separate because I was specifically an integrated behavioral health therapist and he was there for case management type work.

Kristyn identified that she actively partook on the role of relationship building with her coworkers in IBH, not just with the patients she was working with.

When I first started, they had not implemented that annual mental health screening yet. So, the first few weeks that I got there, nobody knew really what I did or what to do with me. I sat there a lot and it was incredibly boring and I was second guessing like, “why am I working here? Is this even going to take off?” I think that initial development of that role can be a little bit tricky. [...] I guess my suggestion or my words of encouragement to anybody who's going to start in that role is to give it some time. And that's what my supervisor said too. And he said the first couple of weeks what my real job was to be, to just build relationships with the physicians because they were going to need to know me if they were going to utilize me.

Kristyn further elaborated that it was much easier for her to utilize her interpersonal skills to initiate conversations with the medical professionals, and it also became much easier for the medical staff to collaborate with her once they had better understandings and trust in each other's responsibilities and expertise. Another role she identified was to learn and teach each other regarding professional duties.

I'm explaining my role to them and then also learning the differences between a nurse practitioner and a PA, or a DO and an MD, and how they might utilize me differently.

### ***Identified Benefits of IBH***

Kristyn was a passionate advocate for IBH practice as well as her site. She identified the team collaboration culture, approachable services for patients, and organizational support for integration of services and training.

Everybody worked really collaboratively. It took a little bit because it was a new position, so they weren't used to having somebody like me on the medical floor. But once we were able to build those working relationships, they trusted me with going in and seeing their patients because it was a small community. [...] It was probably my favorite job. I really loved working in an interdisciplinary team like that. I learned a lot from the primary care physicians about what their life is like, what their schedules are like. I mean they would see 15 people a day and I can't as a clinician. I can't imagine seeing 15 clients a day myself. So, I learned a lot about like what their life was like and how they manage all that, as well as how I come into play in that setting.

Kristyn explained that the collaborative and holistic approach to patient care allowed patients to feel less intimidated about seeking help, which can eventually lead to successful patient buy-in.

I definitely think that [integrated care] makes it more approachable and a lot less scary. Like, “I went to my primary care doctor and while I was there, I saw somebody in mental health” compared to saying like, “I had to pick up the phone and make an appointment for mental health.”

Lastly, her IBH team was committed to providing comprehensive healthcare in order to address issues that rural communities often experience.

It's rural and there's not a lot of specialty healthcare up there. And so the primary care physicians that work there are truly fantastic and addressed everything under the sun as best as they could because, a lot of times the closest specialist was like 45 minutes away.

### ***Barriers to Integration and MUA Care***

Kristyn’s narrative reflected challenges and barriers that rural and medically underserved communities commonly experience in accessing healthcare.

In that rural area, it may be difficult for individuals to travel an hour and a half to go to an appointment. So, a wide variety of presenting physical health issues along with mental health concerns are seen here, from a five-year old for the youngest patient to, patients in their eighties.

Kristyn further explained that because her IBH site in a rural area is oftentimes the only source of healthcare for the community, the IBH team is expected to work with a wide range of patient population with a wide range of physical and behavioral health concerns.

### ***IBH Professional Identity Development***

Kristyn’s IBH counselor identity echoed those of Clare and Jen’s experiences. Kristyn strongly acknowledged the benefits of IBH practice in working with rural and medically

underserved populations, proposed the need to employ mental health counselors in every primary care setting, and encouraged that IBH would be a great opportunity for the counseling field.

I think that it's incredibly important and I could absolutely see the need for it. I also really see the need or at least the movement in the future for more integrated health care settings and getting LPCs into every primary care building, not just [federally qualified health clinics] or VA centers, but really having access to mental health in every primary care location. [...] It was really rewarding. It was really nice to be in that position, in this new position, and be able to offer additional services to people that had maybe never had a chance to access them before.

Similar to what she discussed regarding one of her roles in IBH during early stages of her career, she discussed in journal entry that it was one of her tasks to educate other providers on the counseling profession.

I didn't experience any professional identity issues personally, however it was a task when I first started to educate other providers on what an exactly an LPC does, as well as how I can help them. It was surprisingly to hear, but some didn't even realize we needed a master's degree. So, I spent a lot of time trying to educate people on the different mental health degrees and helping them understand the scope of my practice.

Kristyn also suggested that preparing mental health counselors for IBH settings would not only be beneficial in increasing access to mental healthcare for many underserved populations, but also in increasing the visibility of the counseling field that could offer various incentives for mental health counselors.

I think that these integrated behavioral health practices are going to be a really great opportunity to grow our field. [...] I think that [IBH in underserved areas] probably is

something that could be addressed more because some of those locations also offer really awesome incentives for counselors, like the loan repayment plan. That's certainly something I think that students will be interested in. So, prepping them and helping them find those types of positions and working with them on what that might be like would be helpful.

### ***Educational and Clinical Training Needs***

Kristyn's first exposure to integrated behavioral health was during her master's level internship. She explained that she did not know anything about the concept of integrated services until she started clinical work. She found her diagnosis coursework to be most helpful in preparing her to practice in IBH.

I think just general diagnosing, I had a really good diagnosis class and that's incredibly important in integrated behavioral healthcare because sometimes the primary care providers would take my diagnosis to determine what they are going to do with their treatment.

Kristyn advocated for the inclusion of IBH practices in introductory counseling courses, as IBH can offer various opportunities for counselors.

Maybe in intro to counseling class, I think that it's something that should be discussed because I think these jobs are really incredibly important and I think it's a really awesome opportunity for career development for LPCs too. It's going to open up this whole other option for practice for us. [...] I think that it should be brought up in a master's program, at least the fact that it's out there and it's something that's becoming more popular. And so maybe prepare yourself for that. And then maybe just like a general overview of what

that would look like, or what a handoff looks like, how it looks like when you have 15 minutes to screen somebody for mental illness [should be discussed].

She also added that practicing relevant counseling theories such as the solution-focused brief therapy would be effective in preparing counseling trainees for IBH because it is one of the most utilized techniques in IBH settings. In her journal entry, she found the training on cognitive behavioral healthcare for chronic pain management to be helpful and applicable in integrated settings, as issues with prescription opioid use in chronic pain cases are frequently observed in such settings.

## CHAPTER FIVE

### DISCUSSION AND CONCLUSION

In order to improve accessibility, availability, and approachability of healthcare services in historically marginalized locations in the U.S., the Health Resources & Services Administration (HRSA, n.d.; 2019) implemented a number of federally funded health management and assessment projects, including the Healthcare Provider Shortage Area (HPSA) and Medically Underserved Area (MUA) designations. HPSA is determined by the population to primary, dental, and mental healthcare provider ratio in a particular city or county. Similarly, MUA designations reflect the rates of infant mortality, primary healthcare provider shortage, elderly population, and income level of cities and counties into consideration. Although there is no consensus in defining and classifying rurality, rural healthcare literature collectively suggests that most rural communities share health disparities that are commonly represented in HPSAs or MUAs (Anderson et al., 2015; Joudrey et al., 2019; and Rainer, 2010).

Individuals residing in rural areas, HPSA, and MUA experience unique challenges to healthcare and health management due to poorer social determinants of health (e.g., lower quality of public education, unreliable or inexistent public transportation), location-bound stressors (e.g., stigma regarding help seeking behaviors in rural communities), inequitable distribution of public resources due to lower taxable income, and institutionalized marginalization (e.g., redlining and inequitable zoning) (Artiga & Hinton, 2018; Fiske et al., 2005; Sheldon, 2011; Vogel et al., 2017). Difficulties in recruiting and retaining healthcare providers in rural areas also present a great threat to general public health despite increasing demands for more accessible and efficient healthcare in these areas (Chan et al., 2015; Hendrickx & Winters, 2017).

Integration of mental, behavioral, and primary healthcare has thus been suggested by many healthcare practitioners and researchers as a solution to reduce the impact of disparities in healthcare access (Wan et al., 2018). A systemic integrated behavioral healthcare (IBH) promotes interdisciplinary collaboration between medical professionals, mental healthcare professionals, and other related helping professionals in a co-located setting to provide holistic, high quality, and client-centered healthcare and management services. Literature suggests that IBH is a cost-effective and evidence-based approach to increase accessibility of comprehensive healthcare, early intervention and treatment of health concerns, prevention of illnesses, and efficiency of workflow (Assefa et al., 2019; Lenz et al., 2018; Moe et al., 2018; Park et al., in press; Wan et al., 2018). These benefits of successful integration of services are especially highlighted and valuable in rural, HPSA, and MUA healthcare. IBH significantly reduces travel time and distance for clients in underserved areas with limited resources, creates a streamlined system for health screening, care, management, and follow-ups, allows more thorough psychoeducation, and effectively connects clients with available resources and referrals.

Despite these clear advantages and benefits of integrated behavioral healthcare, interprofessional education (IPE) has only recently started receiving attention. IPE occurs when students from two or more disciplines learn from and with each other via systemic collaboration, or learn about interdisciplinary collaboration (WHO, 2010). In order to effectively prepare students to practice in integrated settings, adequate interprofessional education is essential. With the increasing needs for exhaustive interprofessional education in the medical and healthcare professions, the Interprofessional Education Collaborative (IPEC) was founded in 2009 by six national health education organizations. Currently, IPEC's institutional members consist of 21 medical, health, and helping professionals associations, including: American Association of

Colleges of Nursing, American Dental Education Association, American Psychological Association, Association of American Medical Colleges, and Council on Social Work Education. It is important to note that the Council on Social Work Education is the only helping profession association in the IPEC; there is no professional counseling organization involved in the IPEC to date.

IPEC (2011; 2016) established the Core Competencies for Interprofessional Collaborative Practice, which includes four practice competencies (i.e., values and ethics for interprofessional practice, roles and responsibilities for collaborative practice, interprofessional communication practices, and interprofessional teamwork and team-based practice) and example behavioral expectations. This manual provides foundational knowledge and practical guidelines for interprofessional healthcare, and in turn, more health education accreditation organizations are incorporating specific interprofessional training and education components in their accreditation requirements. Currently, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) serves as the main accreditation board for master's and doctoral level counseling programs. Although CACREP accreditation guidelines indeed include interprofessional education and collaboration as part of the accreditation requirements (CACREP, 2015), they are not specific enough and do not offer any directions on how to implement IPE in counseling programs. As anticipated, the IPE component and its assessments in CACREP-accredited programs are less likely to be uniformed across programs.

### **Purpose, Methodology, and Results of the Study**

This dissertation study was developed in consideration of three core layers: (1) social justice and advocacy issues related to rural, HPSA, and MUA communities, (2) practical applications of integrated behavioral healthcare for mental health counselors, and (3)

interprofessional counselor education and preparation. The main purpose of this study was to explore this overarching research question: *what are lived experiences of mental health counselors in integrated behavioral settings serving rural and medically underserved populations, and their perceptions on educational preparedness?* In order to gain a deeper understanding of a phenomenon on a topic that had not been extensively researched, a phenomenological approach was employed.

In Chapter Three, methodology and its rationales used for this study were discussed in depth. After receiving the Institutional Review Board's approval, a total number of eight (8) participants were recruited. Participant inclusion criteria for this study was: (1) being 18 years old or older, (2) having graduated from a CACREP-accredited master's program in clinical mental health counseling or couples, marriage, & family counseling, and (3) having clinical experiences as a resident in counseling or a licensed professional in integrated behavioral and primary care settings working with rural, HPSA, and MUA populations. Participants were asked to complete a 45-minute semi-structured interview and a journal entry. Participants' narratives were contextually analyzed and thematized by using the Moustaka's 1994 modification of van Kaam's phenomenological data analysis (Hays & Singh, 2012). Collected data was horizontalized and thematized using the following coding steps: (1) listening and preliminary grouping, (2) reduction and elimination, (3) clustering and thematizing the invariant constituents, (4) final identification of the invariant constituents and themes by application, (5) construction of an individual textual description, (6) construction of an individual structural description, and (7) construction of a textural-structural description for each interview transcript. In order to minimize bias and maximize credibility, following strategies were utilized: (1) member

checking, (2) triangulation of data, (3) negative case analysis, and (4) use of researcher reflexive journal and field notes.

Chapter Four discussed the findings and identified themes in detail, with corresponding narratives from the participants. Emerged themes included: (1) multitude of therapist roles in IBH, (2) identified benefits of IBH, (3) barriers to integration and MUA care, (4) IBH professional identity development, and (5) educational and clinical training needs. All participants provided keen insight on integrated behavioral practice, rural and underserved locations, and interprofessional counselor education and preparation through unique narratological lens. Participants' thick descriptions on their clinical experiences and perception on educational preparedness meaningfully contributed to a deeper understanding of counselors' roles in integrated behavioral practices. In this section, thematized narratives will be interpreted in the context of literature and participant experiences. Yet, due to a scarcity of research and literature on mental health counseling in IBH along with interprofessional counselor education, many subthemes were not directly supported by existing literature. Lastly, clinical implications, limitations of this study, and future directions and considerations are addressed.

### ***Descriptions and Implications of Themes and Subthemes***

**Multitude of Therapist Roles in IBH.** One key commonality that emerged among all participants was the multitude of their roles as clinical mental health counselors in integrated practices. In addition to providing mental health therapy to clients and managing universally expected administrative tasks, clinical mental health counselors employed in IBH assumed many more and much more diverse roles and responsibilities at their sites. This theme consisted of six subthemes: (1) client/patient psychoeducation, (2) professional/staff psychoeducation, (3)

client/patient advocacy, (4) “translation”, (5) solution-focused brief consultation, and (6) flexibility/“multiplayer”.

***Client/Patient Psychoeducation and Professional/Staff Psychoeducation.*** Many participants identified that providing client/patient psychoeducation became more important in IBH compared to non-integrated sites. Interestingly, participants collectively shared that they provided professional and staff psychoeducation regarding the counseling profession, scope of practice, mental health and wellbeing, as well as culturally sensitive behaviors and communication. Participants took a proactive and active role on advocating for clients’ mental wellbeing and marketing for the counseling profession. This pattern was similarly observed in the social work literature (Horevitz & Manoleas, 2013). Currently, the majority of behavioral health service providers in primary care settings are social workers; however, little research has been conducted to examine key competencies and preparedness of social workers in IBH. In Horevitz & Manoleas’s 2013 study, a total number of 84 social workers completed a 99-item survey on behavioral health service in IBPH. Respondents identified “knowledge of psychotropic medications (91%), cultural competence (88%), knowledge of family systems (87%), psychoeducation (83%), motivation interviewing (82%), relaxation training (82%), and team-based care (81%)” as key competencies used in the IBH setting (Horevitz & Manolea, 2013). In fact, many findings of this dissertation study echoed the results of the aforementioned study of social workers. It could be inferred that interprofessional research in other disciplines as such would provide insight on future interprofessional counselor education.

***Client/Patient Advocacy and “Translation”.*** Participants often found that they generally had stronger rapport with their clients compared to other health practitioners on site, because of the nature of their relationships, counseling training emphasis on genuineness, unconditional

positive regard, and humility, and the frequency of their meetings. Consequently, counselors were oftentimes the first point of contact in their integrated team to learn about issues with medication management, other health concerns, or life stressors that clients did not feel comfortable sharing with other practitioners or did not have enough time to elaborate to other practitioners. Thus, mental health counselors that participated in this study frequently practiced the role of client/patient advocate in initiating more holistic healthcare and the role of “translator” between medical professionals and clients with limited medical literacy or resources. IBH literature suggests that one of the key downfalls of singular-profession primary healthcare is the patient to provider ratio, and utilization of mental and behavioral healthcare practitioner can effectively moderate this concern (Pincus, 2003; Strosahl, 1998). As mentioned in this dissertation study, it was apparent that the PCPs did not have enough time to provide thorough consultations or psychoeducation on health behaviors, which indirectly exposes clients with continued unsound health habits that hinder progress. Mental health and behavioral counselors can effectively bridge this gap in provider-patient communication while building strong rapport with everyone involved in care.

***Solution-Focused Consultation.*** Additionally, participants in this study were expected to provide solution-focused consultations to medical professionals and their clients, that significantly expanded the boundaries of traditional individual or group mental health therapy. For example, mental health clinicians in this study were expected to share instantaneous diagnostic impression to the IBH team, utilize problem-solving skills to secure bus passes for clients, and provide speedy, provide brief and immediate consultations for any behavioral inquiries. While this subtheme offers a fundamental understanding of roles and identities of IBH counselors, it is as important to note that this is a skill that the clinicians learned on-the-job, not

during their educational training. Evidence-based counseling techniques are perhaps one of the most underrepresented areas in integrated behavioral healthcare literature. This setback could be attributed to the low visibility of behavioral counseling in counseling research, universal challenges associated with conducting evidence-based techniques research, and a considerably wider range of diagnoses and treatment observed in integrated settings. In order for more comprehensive and relevant IPE, counselor educators and practitioners must actively research and incorporate these diversified functions of IBH counselors.

*Flexibility/“Multiplayer”*. There was an increased need for a higher level of flexibility in treating a wide array of mental health concerns and comorbid issues observed in the study. Mental health counselors in integrated primary care settings have much less autonomy in working with a specific subset of diagnostic clusters or populations since primary healthcare is intended to serve as the first point of contact for any and all individuals with health concerns. While flexibility is a rather abstract concept to be referred as a “professional role,” it could be compartmentalized to hold more compatible practical values. For instance, Whitlock et al. (2002) modified tobacco cessation interventions and developed the Five As (i.e., assess, advise, agree, assist, and arrange) as best practice in flexible, brief behavioral consultation. These constructs portray the essence of integrated practices while accurately capturing the clinical experiences and expectations of IBH mental health counselors in this study. The Five As may offer some insight into future development of evidence-based behavioral counseling techniques in IBH.

**Identified Benefits of IBH.** Participants in this study strongly agreed that integration or behavioral and primary care services is a necessity in providing healthcare access to vulnerable individuals with limited resources. This theme was categorized in five subthemes: (1) convenience of co-located services, (2) holistic & client/patient-centered approach, (3) burnout

prevention, (4) increased introspection & reflexivity, and (5) interprofessional learning & growth. One of the most noticeable benefits of integrated services is the convenience of co-located services.

***Convenience of Co-Located Services.*** As discussed in earlier chapters as well as in participant narratives, many individuals in rural, HPSA, and MUA communities do not have reliable transportation options and oftentimes have to travel more than 45 minutes for healthcare due to practitioner and facility shortages in the area. In addition to streamlining the workflow of collaborating healthcare practitioners, co-location of interdisciplinary services significantly reduces travel time and distance for clients and creates a more approachable healthcare system to all.

***Holistic & Client-Centered Approach.*** IBH also supports a holistic and client-centered approach in healthcare and management. Comorbid issues are handled more efficiently, life stressors or harmful health behaviors are addressed early on, and clients are supported by an integrated team of diverse healthcare disciplines. These benefits and key characteristics of IBH are congruent with previous research and literature (Assefa et al., 2014; Gleason et al., 2014). Traditionally, the medical model of healthcare has focused more on immediate problem solving and treatment of presenting diseases. While the medical model does have some advantages, researchers have argued that it may not be the most culturally inclusive approach to primary healthcare, as it overlooks significant systemic factors such as health behaviors and life stressors. Integrated services ensure that healthcare practitioners with various expertise equally participate in client healthcare and management in a more holistic sense (Gleason et al., 2014). For instance, while the primary care physician screens for general physical health concerns for a patient with hypertension and generalized anxiety disorder, a mental health counselor can provide regular

therapy sessions to address the symptoms of anxiety, a dietician can provide education on hypertension and healthy eating, and a psychiatric nurse practitioner can assist with medication management.

***Burnout Prevention/Shared Responsibilities.*** Another interesting subtheme that has emerged during the analysis was the prevention of practitioner burnout. Healthcare professionals in a systemically and institutionalized IBH team share client care responsibilities that are more congruent to their expertise and scope of practice. For instance, a mental health counselor in a poorly integrated practice or a non-integrated site may be required to spend extra time on tasks that are generally initiated by social workers or case managers. Shared responsibilities in healthcare among practitioners can prevent symptoms of burnout and lessen the burden for individual practitioners. Burnout, or compassion fatigue in healthcare professionals can lead to detrimental results in client as well as self-care. Symptoms of burnout include depression, anxiety, sleep disturbance, hopelessness and suicidality, fatigue, substance use, and interpersonal dysfunctions (Kumar, 2016). Prevalence rate and levels of burnout differ based on clinical setting, countries and regions, and specialties in medical doctors.

One recent study indicated that burnout rates in U.S. physicians are constantly increasing, with higher rates of dissatisfaction and fatigue observed in urology, physical medicine and rehabilitation, and family medicine (Shanafelt et al., 2015), with family medicine physicians being the leading healthcare providers in rural areas in numbers. Despite the chronic exposure to stressful work environments, there is a scarcity of research regarding burnout prevention and intervention tactics for medical and health professionals. Yet, when 1,400 physicians in rural and remote areas of Australia were assessed to determine factors that assist with workforce retention, it was revealed that institutional support for better on-call arrangements, professional support for

medical education and recreation, variety of rural practice, and local availability of services as key factors (Humphreys, Jones, Jones, & Mara, 2002). This study sheds light on another advantage of IBH practice in rural and medically underserved areas, in which there is built-in professional support and referrals from a diverse range of health practitioners. Examining the correlations or causality of these concerns in IBH settings would tremendously raise awareness in quality healthcare practice and provider retention in remote, underserved areas.

***Increased Introspection & Reflexivity and Interprofessional Learning & Growth.***

Successful integration of behavioral and primary care can increase introspection and reflexivity in mental health counselors and stimulate interprofessional learning and growth. Participants of this dissertation study recalled that interprofessional collaboration challenged them to think critically, offered unique perspectives in healthcare approaches, and gave them opportunities to reflect on their own learning and growth as a counselor and a collaborator. IPEC's (2016) Core Competencies for Interprofessional Collaborative Practice framework recognized the importance of continuous interprofessional collaboration, education, and development as part of the sub-competencies of Roles and Responsibilities for Collaborative Practice. The IPEC framework outlines that through interprofessional collaboration, practitioners are to

engage health and other professionals in shared patient-centered and population-focused problem-solving, ... engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise..., ... reflect on individual and team performance for individual, as well as team, performance improvement, [and] use process improvement to increase effectiveness of interprofessional teamwork and team-based services, programs, and policies (IPEC, 2016, p. 14).

It is unclear whether the participants of this dissertation study or their collaborators received any trainings specific to the IPEC competencies; however, the results indicated that the participants' clinical experiences were congruent with the IPEC values.

**Barriers to Integration and MUA Care.** In rural and medically underserved population care, lack of available resources, healthcare provider shortage, and low accessibility may also have adverse impact on healthcare practitioners. This theme with a strong emphasis on social justice issues generated four subthemes: (1) lack of resources & accessibility, (2) level of integration and site commitment, (3) decreased applicability of counseling theories, and (4) lack of understanding in professional responsibilities.

***Lack of Resources & Accessibility.*** Though IBH may serve as a moderating factor for individual practitioner burden, such facility may be one of a few available healthcare resources for a large population in rural or medically underserved areas. Client flow and caseload is extremely difficult to control even for integrated practices, especially when there is a scarcity of options for healthcare and they have to cover much bigger geographical regions. Participants of this study disclosed experiencing varied levels of helplessness and fatigue while discussing the lack of resources and limited accessibility to healthcare in remote areas. This subtheme predominantly reflects the existing rural and underserved population healthcare literature.

***Level of Integration and Site Commitment.*** Subsequently, some participants in this study pointed out that the levels of integration at their practice and organizational commitment to integration significantly affected their ability to provide competent care. In one case, it was apparent that the participant did not receive adequate support and collaboration guidelines from the administrators regarding integration of services at a pro bono clinic mostly staffed by trainees and volunteers. Levels of Integration defined by the SAMHSA-HRSA Center for Integrated

Health Solutions (n.d.) range from informal referral systems between primary healthcare practitioners and mental health counselors to a systemic integration of co-located primary and behavioral services. To date, there is lack of research examining the impact of levels of integration on healthcare outcomes, effectiveness, or practitioner satisfaction. However, it can be inferred that higher levels of integrated services would have more clear and comprehensive advantages in healthcare and practitioner retention in underserved areas.

***Decreased Applicability of Counseling Theories.*** Participants of this study oftentimes discussed the distinct differences of IBH practices and non-integrated practices. One of the key differences that universally identified was the decreased applicability of traditional counseling theories. As discussed above, IBH practice significantly expands the roles and responsibilities of mental health counselors beyond the traditional boundaries of 60-minute, individual or group counseling. Current counseling theories are mainly focused on these basic modalities in non-integrated settings; consequently, these textbook approaches in counseling have less transferability in integrated settings, especially serving rural and underprivileged populations. One participant of the study pointed out that a developmental approach to career counseling seemed inappropriately luxurious in working with individuals struggling with poverty and unemployment in rural areas in the U.S. He added that the counseling theories he learned during his master's program were unsuitable and prejudiced in areas with limited resources and high unemployment rate. Along with the need for developing consultation-relevant best practice, it would be critical to thoroughly investigate the cultural and geographical inclusiveness of current counseling theories in counselor education.

***Lack of Understanding in Professional Responsibilities.*** One of the most frequently discussed constructs in the study was the lack of understanding in professional responsibilities in

IBH settings. Many participants echoed that they were required to learn other practitioners' scope of practice and professional cultures in order to be a successful team member. At the same time, many practitioners from other disciplines were not familiar with the roles of counselors in integrated settings. This lack of understanding in professional responsibilities were reflected in practitioners spending more time gauging 'who is who and who does what,' which eventually evolved into an additional burden to practitioners. This again calls for a clearer and more streamlined IPE guidelines and organizational/administrative commitment to integration of multiple disciplines.

**IBH Professional Identity Development.** Four (4) distinct subthemes were identified for this theme: (1) counselor identity development, (2) counseling profession advocacy, (3) promotion of IBH awareness and integration, and (4) understanding differences in healthcare professions. Mental health counselors in integrated practice settings in this study expressed that developing and fostering their counselor identity was critical in becoming a competent team member of IBH. Further discussion on counselor and IBH practitioner identity development is included in the Applications for Clinical Practice and Counselor Education section below. Participants of this study found themselves to be strongly invested in advocating for and providing education on the counseling profession in their integrated settings. Some recalled encountering healthcare practitioners who were not familiar with the scope of practice of mental health counselors, and as a result, they proactively marketed their professional expertise and skills that could be utilized in IBH care and actively educated other healthcare professionals on the roles of mental health counselors. While navigating the interprofessional encounters, counselors also found the need to learn and understand the cultural differences among the professionals.

As previously mentioned, findings for this theme are congruent with the competencies identified in Horevitz & Manoleas' 2013 study on social workers in IBH settings as well as the IPEC's Core Competencies for Interprofessional Collaborative Practice (2016). IPEC's Competency 2: Roles and Responsibilities includes the following sub-competencies (p. 12):

- RR1. Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals*
- RR2. Recognize one's limitations in skills, knowledge, and abilities*
- RR3. Engage diverse professionals who complement one's own professional expertise, as well as associated resources to develop strategies to meet specific health and healthcare needs of patients and populations*
- RR4. Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease*

There is no literature on counselor identity development in integrated behavioral settings, but findings in this study paired with the IPEC competencies could provide conducive directions on interprofessional counselor education development.

**Educational & Clinical Training Needs.** Lastly, four subthemes were identified for educational and clinical training needs: (1) foundations of counseling, (2) IBH awareness, (3) on-the-job training, and (4) evidence and theory-based techniques for specialty care. Most participants of this study acknowledged that integrated behavioral healthcare was not part of their educational curricula, and a need for an increased IBH awareness and exposure during master's level counseling programs. This result raises a question regarding the enforcement of current CACREP standards for interprofessional collaboration. A total of five CACREP standards (i.e., 2.F.1.b, 2.F.1.c, 5.D.2.b, 5.D.3.b, and 5.H.3.1) instruct accredited programs to include the multiple professional roles and functions of counselors in integrated behavioral healthcare systems, professional relationships between counselors and medical professionals, strategies for medical interprofessional collaboration, and interdisciplinary consultation in counselor education curricula. All participants in this dissertation study were graduates of

CACREP-accredited master's level counseling programs; however, they did not recall having sufficient education or training in integrated behavioral healthcare or interprofessional collaboration. Therefore, the results of this dissertation study could significantly contribute to developing a more effective IBH education curriculum for counseling trainees.

### **Applications for Clinical Practice and Counselor Education**

This study presented a number of clinical and educational implications in the field of counseling, counselor education, and interprofessional education. The following section further expounds on the findings of this study and highlights the gravity of this study in regard to current literature and practice.

### ***Significance of Social Determinants of Health (SDOH) in Counseling***

As suggested in the participant narratives as well as health literatures, clients with poorer social determinants of health face many challenges in seeking healthcare and managing health outcomes (Tumber et al., 2019). This study revealed that many residents in rural, Healthcare Provider Shortage, and Medically Underserved Areas encounter poor SDOH due to systemic marginalization and inequitable distribution of public resources. Commonly identified SDOH and barriers to healthcare in medically underserved locations included lack of transportation, food insecurity, limited options for employment, and lower levels of income. These health disparities are not only an immense barrier in accessing healthcare, but also an implicit burden to healthcare providers. Adverse impact of SDOH cannot be sufficiently managed without integration of services, and systemic integration of services cannot occur without proper education and preparation in all involved professions. Healthcare providers in rural and medically underserved areas need to be able to recognize the SDOH that could risk healthcare and outcomes, determine appropriate services for comprehensive care, establish an efficient

network of referral systems, and develop professional advocacy strategies to mitigate health inequality.

Participants of this study shared that their position in integrated behavioral healthcare required them to practice an elevated level of flexibility to more effectively address the issues of persistent, negative impact of poor social determinants of health in underserved areas.

Additionally, participants all agreed that because of their positionality in integrated settings as a mental health counselor, their rapport with clients seemed to be more robust compared to other healthcare providers. Therefore, mental health counselors are oftentimes at the forefront of observing and discovering clients' health behaviors and social determinants of health in IBH settings, yet our educational training is much more focused on providing therapy and building therapeutic relationships. In order to produce IBH-competent and culturally informed counselors, more extensive counselor education in assessing and addressing SDOH is essential. First, concepts of flexibility, humility, and openness have been repeatedly mentioned in the participant narratives. One way to revamp current counselor education curricula and trends would be to include these core counselor elements' implications and applicability in coursework outside multicultural counseling. For instance, counseling trainees may practice immediate decision-making skills in IBH case scenarios, SDOH assessments and their impact with colleagues, and a wider array of therapy modalities, such as brief consultations or telehealth.

Additionally, in order to effectively tackle the issues of poor SDOH in rural and medically underserved populations, counselor education programs must provide adequate education on the roles and scope of practice of other helping professionals so that counselors learn how to identify appropriate referrals and initiate interprofessional collaboration.

Furthermore, results of this study supported the need for continued research in evidence-based

practices for individuals with poorer social determinants of health and harmful health behavioral patterns. “Traditional” 60-minute weekly individual counseling is less likely to be the best modality for vulnerable populations with limited resources and access. Thus, it would be fundamental to incorporate more diverse theories, best practices, and modalities of counseling that are more inclusive, sensitive, and population-appropriate in counselor education. Lastly, professional counseling organizations must continue to lobby and promote social advocacy efforts to ensure increased access to mental health services and increased integration of primary and behavioral healthcare.

### ***Increased Access to Mental and Primary Healthcare to Vulnerable Populations***

Vulnerable populations focused in this study included individuals in rural, Healthcare Provider Shortage, and Medically Underserved Areas. Results of this study indicated that these individuals are met with numerous disadvantages in all aspects of their daily life, including healthcare and management. The Health Resources & Services Administration (HRSA, 2015) reiterated the needs for healthcare infrastructure improvement on “accessibility, availability, and acceptability of mental health services” (p. 480). Participants of this study collectively identified that the majority of their clientele did not have reliable transportation options to access healthcare, did not have healthcare facilities nearby, and were not familiar with mental health and behavioral healthcare services available to them. Integrated behavioral and primary healthcare practice aids in minimizing these common adversities. IBH offers opportunities for the vulnerable and underserved populations to receive comprehensive healthcare in one setting, greatly reduces travel time needed for comprehensive care, provides client psychoeducation from diverse perspectives, and allows for more approachable and accessible services. Many participants of this study identified that their clients were not knowledgeable with healthcare

services available or necessary for them until they were introduced to IBH. Additionally, it is more likely that IBH practice would produce better healthcare provider recruitment and retention in rural and provider shortage areas as systemic integration protects practitioners from burnout and promises more effective workflow. Integration of services provides a safety net for individuals with intersected, multiple marginalized identities.

Integrated behavioral healthcare also increases awareness of health behaviors and visibility of mental health counseling. In many rural, underserved areas in the U.S., there is still a high level of stigma and misconceptions regarding help seeking behaviors, mental health, and psychological wellbeing (Arbore, 2019). Participants of this study echoed that client psychoeducation was often one of their primary responsibilities as an IBH counseling practitioner, as many of their clients were unfamiliar with mental health services and thus did not know what type of services to seek for. Basic health behavior education on personal hygiene, sleep hygiene, eating habits, and stress coping strategies can contribute to general public health and prevention of many chronic illnesses, such as hypertension and diabetes. Increased access to holistic healthcare via IBH also allows early detection and treatment of illnesses, as clients are more likely to become aware of their baseline health, changes in symptoms, and available resources. Rigorous and proactive integration of healthcare services may put an end to the institutionalized and transgenerational healthcare detriments in vulnerable populations in the U.S.

### ***Diversified Career Opportunities for Counseling Professionals and Trainees***

Since the integration of healthcare services first gained attention in the 1970s (Smalley et al., 2010), there have been multiple national and organizational movements to study, support, and implement IBH services, especially in the medical and medical education field. While

professional mental health counselors are an essential part of the IBPH team and they are in the best position to serve as behaviorists in integrated settings, this discussion or advertisement is grossly overlooked in counselor training programs. Many participants in this study agreed that they were unaware of counselors' involvement in integrated primary care settings during their master's level counseling training. There is a need for greater exposure of various career options for counselors as well as more robust career development opportunities in counselor education, such as specialty certification or advanced elective coursework. Such interests could encourage counseling trainees to explore career paths that are not just limited by private practice or community mental health facilities. Strong and solid foundations as a clinical mental health counselor are an uncompromisable starting point; however, the counseling field also needs clinicians with IBH expertise, clinicians providing trainings for law enforcement, clinicians developing counseling-focused liability insurance, and so on. Counseling trainees are more likely to become interested and better prepared for integrated settings through more comprehensive counselor education curricula.

### ***Counselor and IBH Practitioner Identity Development Processes***

Last clinical and educational implication of this research purpose worth noting is the counselor and IBH practitioner identity development. The development and fostering of counselor identity is one of the core functions of master's level training programs as well as various professional counseling organizations. Counselor identity development is a continuous, reflexive, and fluid process in which the individual integrates professional values, attitudes, and actions that are universally championed by the profession (ACA, 2014; Lile, 2017). While these core counselor identity elements are collectively embraced by the profession, the identity development is an individualized and distinctively unique process. Berzonsky's (1989) theory of

identity styles suggested that when an individual is met with identity-related issues, they exhibit one of three main processing types: (1) diffuse/avoidant, (2) normative, and (3) informational styles. The diffuse/avoidant style is associated with avoidant tendencies when met with identity-related decisions and lower levels of emotional intelligence and self-actualization. The normative style is characterized by social norm-oriented development processes and valuing of tradition, conformity, and security. The informational style is represented by information-oriented decision making and higher levels of emotional intelligence and self-actualization.

Participants of this study emphasized their roles and involvement in advocating for and promoting their counselor identity and the counseling profession during their IBH experiences. It was suggested that they were met with far more opportunities and encounters to reflect on their professional identities and positionality within the practice as they collaborated with practitioners from other disciplines, whereas they suspected that there would not be as many opportunities to do so in non-integrated settings. This statement offers critical insight on counselor identity development processes and introduces a potential shift in counselor education. Firstly, counselor identity development may begin with within-group interactions (e.g., counseling trainee – counselor educator), but counselor identity practice or application may occur more frequently during between-group encounters (e.g., counselor – medical doctor/social worker). Secondly, all participants of this study utilized the informational style (Berzonsky, 1989) when advocating for their position and the counseling profession. The informational style approach to identity-related challenges is characterized by proactiveness, self-actualization, pragmatic maturity, and openness to new experiences, which are all compatible to many components of successful IBH practitioner identity that the participants had shared during the interview. This phenomenon calls

for further research in counselor identity development as well as interprofessional education in the counseling field.

### **Limitations**

As phenomenological research allows for a thick, contextual description of commonalities found among research participants' experiences, a small sample size limits the generalizability of the phenomenon (Hays & Singh, 2012; Offet-Gartner, 2010). Through purposeful sampling, participants recruited for this study shared a wide range of integrated clinical experiences from medication-assisted substance use treatment to family medicine residency training. Although the type of settings and localities varied greatly in this sample, the study may have benefited from examining more diversified positions that mental health counselors hold in integrated settings. For instance, a mental health counselor who oversees and supervise behavioral health clinicians may further enrich the narrative paradigm emerged in this study. Despite the reduced generalizability due to a small sample size, results of this study offer an integral understanding of current platforms of integrated behavioral healthcare in under-represented locations and gaps in counselor education and preparation.

Another limitation this study potentially encountered is the social desirability bias and participant bias. Social desirability in research is one of common drawbacks found in self-report or interview formats, in which participants show tendency to respond in a way that they perceive to be more socially acceptable (King & Bruner, 1999). All eight participants of this study strongly agreed that integrated behavioral healthcare is beneficial and necessary in order to increase healthcare access and ensure quality of client care with comorbid health concerns. Therefore, participants may have responded to interview questions in a way that is more congruent with their beliefs, while underrating their authentic feelings and experiences with

practice and educational training. Similarly, participant bias may have hindered their genuine feedback. Participant bias, or response bias occurs when participants have assumptions regarding the purpose of the research and provide statements that they perceive to be more congruent with the assumed research direction (Gove & Geerken, 1977). It is plausible that the participants inferred that the researcher agenda may have included probing for the benefits of IBH in medically underserved settings or the effectiveness of CACREP guidelines in preparing IBH practitioners. Although researcher assured confidentiality of participant responses and established rigorous research protocols using two different data collection methods, it was unattainable to completely control these limitations beyond standard measures.

### **Recommendations for Future Research**

This study offers many directions for future research. First, integrated behavioral and primary healthcare practice is becoming more of a necessity in providing accessible healthcare and resources to a diverse range of population. The results of this study suggested that mental health counselors are an essential part of the integrated practice in terms of promoting integration, providing behavioral and mental health services, and advocating for clients. As it is predicted that there would be more opportunities for mental health counselors to join integrated practices, it is imperative that the field of counselor education adequately prepares counseling trainees during their academic career. Integrated clinical practice also calls for a greater need for interprofessional education, in which students and trainees from various disciplines learn with and from each other (WHO, 2010). This study does not only call for more robust inclusion of interprofessionalism in counselor education, but also for an interdisciplinary learning environment for health professional students. This study addresses a gap in counselor education curriculum in CACREP-accredited programs. CACREP requires the inclusion of IPE and its core

components; however, the implementation and assessment of IPE differs significantly from program to program.

This study also looked into the impact of privilege disparity based on localities. Rural, HPSA, and MUA residents experience a myriad of disadvantages including financial instability, lack of resources, unreliable transportation, and medical illiteracy that all pose a significant threat to their healthcare and management. More effective and relevant ways to teach multicultural counseling courses along with topics of intersectionality of marginalization, systemic and institutionalized oppression in the U.S., and culturally sensitive and inclusive counseling theories and techniques need to be further developed and practiced. At the national and state organizational level, counseling professions must continue to lobby and advocate for policies that would diminish the transgenerational inequality experienced by the historically minoritized populations in the U.S., and continue to produce evidence-based advocacy initiatives such as the Health Center and Health Workforce Training Programs (HRSA, n.d.).

Lastly, it is critical to acknowledge the implications of current world issues. During the later course of this research, the unprecedented COVID-19 outbreak took place and was declared as a Public Health Emergency of International Concern (WHO, 2020). This historical infectious disease outbreak has already jeopardized healthcare infrastructures around the world and disrupted every aspect of daily life. In the U.S., the unemployment rate skyrocketed due to business closures, quarantine practices, and lockdown/shelter-at-home orders; a record-high number of 3.3 million Americans filed for unemployment as of March 2020, approximately three months after the first confirmed COVID-19 case (Long & Fowers, 2020). Healthcare facilities have been overexerted with the rapidly and continuously escalating infection rates while managing with limited understanding of the disease and concerningly insufficient basic medical

supplies. The academic year has ended abruptly in mid-March for k-12 system in most states (Office of the Governor of Virginia, 2020), and higher education institutions suspended all in-person classes for the rest of this academic year. Many graduate level counseling students were met with practicum and internship site closures and many counseling professionals are transitioning into tele-mental health modalities with little to no time for preparation or training. It is highly likely that this pandemic will change our lives and society permanently. Integration of behavioral and primary healthcare can serve as an effective and vital buffer to public health, during such times with unusually heightened anxiety and depression levels. It is urgent, timely, and vital for the counseling profession to prepare for a substantial shift in healthcare and education post-COVID-19.

## References

- Agency for Healthcare Research and Quality (2015). *Chartbook on rural health*.  
<https://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/ruralhealth/index.html>.
- Alvesson, M., & Sköldbberg, K. (2000). *Reflexive methodology: New vistas for qualitative research* (2<sup>nd</sup> 3d.). Sage Publications.
- American Academy of Family Physicians. (n.d.). *Primary care*.  
<https://www.aafp.org/about/policies/all/primary-care.html>
- American Counseling Association. (2014). *Code of Ethics*. Alexandria, VA: Author.
- Anderson, T. J., Saman, D. M., Lipsky, M. S., & Lutfiyya, M. N. (2015). A cross-sectional study on health differences between rural and non-rural U.S. counties using the County Health Rankings. *BioMed Central Health Services Research*, 15, 441-449.
- Assefa, M. T., Ford II, J. H., Osborne, E., McIlvaine, A., King, A., Campbell, K., Jo, B., & McGovern, M. P. (2019). Implementing integrated services in routine behavioral health care: Primary outcomes from a cluster randomized controlled trial. *BioMed Central Health Services Research*, 19, 749-762. <https://doi.org/10.1186/s12913-019-4624-x>
- Arbore, P. (2019). Suicide prevention among rural older adults. *Journal of the American Society on Aging*, 43(2), 62-65.
- Artiga, S., & Hinton, E. (2018, May 10). *Beyond health care: the role of social determinants in promoting health and health equity*. Kaiser Family Foundation.  
<https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

- Basu, S., Landon, B. E., Williams Jr., J. W., Bitton, A., Song, Z., & Phillips, R. S. (2017). Behavioral health integration into primary care: A microsimulation of financial implications for practices. *Journal of General Internal Medicine, 32*(12), 1330-1341.
- Barr, H. (1998). Competent to collaborate: Towards a competency-based model for interprofessional education. *Journal of Interprofessional Care, 12*, 181-187.
- Beacham, A. O., Kinman, C., Harris, J. G., & Masters, K. S. (2012). The patient-centered medical home: Unprecedented workforce growth potential for professional psychology. *Professional Psychology: Research and Practice, 43*, 17-23.
- Berzonsky, M. D. (1989). Identity style: Conceptualization and measurement. *Journal of Adolescent Research, 4*, 268-282. <https://doi.org/10.1177/074355488943002>
- Bridges, D., Davidson, R., Odegard, P., Maki, I., & Tomkowiak, J. (2011). Interprofessional collaboration: Three best practice models of interprofessional collaboration. *Medical Education Online, 16*, 1-10. <https://doi.org/10.3402/meo.v16i0.6035>
- Chan, Y., Lu, S., Howe, B., Tieben, H., Hoeft, T., & Unützer, J. (2015). Screening and follow-up monitoring for substance use in primary care: An exploration of rural-urban variations. *Journal of General Internal Medicine, 31*(2), 215-222. <https://doi.org/10.1007/s11606-015-3488-y>
- Coleman, J. V., & Patrick, D. L. (1976). Integrating mental health services into primary medical care. *Medical Care, 14*(8), 654-661.
- Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91.

- Council for Accreditation of Counseling and Related Programs. (2015). *2016 CACREP standards*. <http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf>
- Cox, J., Adams, E., & Loughran, M. J. (2014). Behavioral health training is good medicine for counseling trainees: Two curricular experiences in interprofessional collaboration. *Journal of Mental Health Counseling, 36*(2), 115-129.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches*, (4th ed.). Sage Publications.
- Davis, M., Balasubramanian, B. A., Waller, E., Miller, B. F., Green, L. A., & Cohen, D. J. (2013). Integrating behavioral and physical health care in the real world: Early lessons from advancing care together. *Journal of American Board of Family Medicine, 26*(5), 588-602. <https://doi.org/10.3122/jabfm.2013.05.130028>
- Doll, J., Packard, K., Furze, J., Huggett, K., Jensen, G., Jorgensen, D., Wilken, M., Chelal, H., & Maio, A. (2013). Reflections from an interprofessional education experience: Evidence for the core competencies for interprofessional collaborative practice. *Journal of Interprofessional Care, 27*, 194-196. <https://doi.org/10.3109/13561820.2012.729106>
- Fiske, A., Gatz, M., & Hannell, E. (2005). Rural suicide rates and availability of health care providers. *Journal of Community Psychology, 33*(5), 537-543.
- Gleason, H., Hobart, M., Bradley, L., Landers, J., Langenfeld, S., Tonelli, M., & Kolodziej, M. (2014). Gender differences of mental health consumers accessing integrated primary and behavioral care. *Psychology, Health & Medicine, 19*, 146-152. <https://doi.org/10.1080/13548506.2013.793371>
- Gove, W., & Geerken, M. (1977). Response bias in surveys of mental health: An empirical

- investigation. *American Journal of Sociology*, 82(6), 1289-1317.  
<https://doi.org/10.1086/226466>
- Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. Guilford Press.
- Health Resources & Services Administration. (n.d.). *HRSA behavioral health*.  
<https://www.hrsa.gov/behavioral-health>
- Health Resources & Services Administration. (2013). *Achieving health equity through nursing workforce diversity*. <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/2013-eleventhreport.pdf>
- Health Resources & Services Administration. (2019). *Designated health professional shortage areas statistics*. <https://bhw.hrsa.gov/shortage-designation/hpsa-criteria>
- Hendrickx, L., & Winters, C. (2017). Access to continuing education for critical care nurses in rural or remote settings. *Critical Care Nurse*, 37(2), 66-71.
- Hepp, S. L., Suter, E., Jackson, K., Deutschlander, S., Makwarimba, E., Jennings, J., & Birmingham, L. (2015). Using an interprofessional competency framework to examine collaborative practice. *Journal of Interprofessional Care*, 29(2), 131-137.  
<https://doi.org/10.3109/13561820.2014.955910>
- Humphreyes, J. S., Jones, M. P., Jones, J. A., Mara, P. R. (2002). Workforce retention in rural and remote Australia: Determining the factors that influence length of practice. *Medical Journal of Australia*, 176(10), 472-476.
- Holder, K. A., Fields, A., & Lofquist, D. (2016, Dec 8). *Rurality matters*. U.S. Census Bureau.  
[https://www.census.gov/newsroom/blogs/random-samplings/2016/12/rurality\\_matters](https://www.census.gov/newsroom/blogs/random-samplings/2016/12/rurality_matters)

- Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social Work in Health Care, 52*(8), 752-787. <https://doi.org/10.1080/00981389.2013.791362>
- Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update*. Interprofessional Education Collaborative.
- Interprofessional Educational Collaborative (IPEC) Expert Panel. (2011). *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel*. Interprofessional Education Collaborative.
- Johnson, K. F., & Freeman, K. L. (2014). Integrating Interprofessional Education and Collaboration Competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling, 36*(4), 328–344.  
<https://doi.org.proxy.lib.odu.edu/10.17744/mehc.36.4.g47567602327j510>
- Joudrey, P. J., Edelman, E. J., & Wang, E. A. (2019). Drive times to opioid treatment programs in urban and rural counties in 5 US States. *Journal of American Medical Association, 322*(13), 1310-1312. <https://doi.org/10.1001/jama.2019.12562>
- King, M. F., & Bruner, G. C. (1999). Social desirability bias: A neglected aspect of validity testing. *Psychology & Marketing, 17*(2). [https://doi.org/10.1002/\(SICI\)1520-6793\(200002\)17:2<79::AID-MAR2>3.0.CO;2-0](https://doi.org/10.1002/(SICI)1520-6793(200002)17:2<79::AID-MAR2>3.0.CO;2-0)
- Klein, S., Hostetter, M. (2014). *In focus: Integrating behavioral health and primary care*. Quality Matters. <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus>
- Kumar, S. (2016). Burnout and doctors: Prevalence, prevention and intervention. *Healthcare, 4*(37). <https://doi.org/10.3390/healthcare4030037>

- Lee, J., McKennett, M., Rodriguez, X., & Smith, S. (2018). Implementation and evaluation of a recurring interdisciplinary community health fair in a remote U.S.-Mexico border community. *Journal of Immigrant and Minority Health, 21*, 136-142.  
<https://doi.org/10.1007/s10903-018-0718-5>
- Lenz, A. S., Dell'Aquila, J., & Balkin, R. S. (2018). Effectiveness of integrated primary and behavioral healthcare. *Journal of Mental Health Counseling, 40*(3), 249-265.
- Lile, J. J. (2017). Forming a professional counselor identity: The impact of identity processing style. *Journal of Counselor Preparation and Supervision, 9*(2).  
<https://doi.org/10.7729/92.1163>
- Long, H., & Fowers, A. (2020, Mar 26). *A record 3.3 million Americans filed for unemployment benefits as the coronavirus slams economy*. Washington Post.  
<https://www.washingtonpost.com/business/2020/03/26/unemployment-claims-coronavirus-3-million/>
- McCarthy, J. F., Blow, F. C., Ignacio, R. V., Ilgen, M. A., Austin, K. L., & Valenstein, M. (2012). Suicide among patients in the Veterans Affairs health system: Rural-urban differences in rates, risks, and methods. *American Journal of Public Health, 102*(S1), 111-117.
- Mellin, E., Hunt, B., & Nichols, L. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*(2), 140-147
- Moe, J., Johnson, K., Park, K. & Finnerty, P. (2018). Integrated behavioral health and counseling gender and sexual minority populations. *Journal of LGBT Issues in Counseling, 12*(4), 215-229. <https://doi.org/10.1080/15538605.2018.1526156>

- Najmi, S. (2013). *A qualitative exploration of international students' experience of counseling services at university* (Unpublished master's dissertation). University of Ottawa, Ottawa, Canada.
- National Rural Health Association. (n.d.a). *About the National Rural Health Association*.  
<https://www.ruralhealthweb.org/about-nrha>
- National Rural Health Association. (n.d.b). *About rural health care*.  
<https://www.ruralhealthweb.org/about-nrha/about-rural-health-care>
- Offet-Gartner, K. (2010). Engaging in culturally competent research. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling* (2nd ed, pp. 209-246). Counselling Concepts.
- Office of the Governor of Virginia. (2020, Mar 23). *Governor Northam orders statewide closure of certain non-essential businesses, K-12 Schools*. Commonwealth of Virginia.  
<https://www.governor.virginia.gov/newsroom/all-releases/2020/march/headline-855292-en.html>
- Park, K., Rivas, F., Borden, N., & Carlisle, K. (In Press). Preparing practice-ready collaborative healthcare human services students: Considerations on developing interprofessional education competencies in Human Services. *Journal of Human Services*.
- Peek, C. J., & National Integration Academy Council. (2013). *Lexicon for behavioral health and primary care integration*. Agency for Healthcare Research and Quality. 13-IP001-EF.  
<https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>
- Pincus, H. A. (2003). The future of behavioral health and primary care: Drowning in the mainstream or left on the bank? *Psychosomatics: Journal of consultation and Liaison Psychiatry*, 44(1), 1-11. <https://doi.org/10.1176/appi.psy.44.1.1>

- Rainer, J. P. (2010). The road much less travelled: Treating rural and isolated clients. *Journal of Clinical Psychology, 66* 475-478.
- Ratcliffe, M., Burd, C., Holder, K., & Fields, A. (2016). Defining rural at the U.S. Census Bureau. *American Community Survey and Geography Brief*.
- Redford, L. J. (2019). Building the rural healthcare workforce: Challenges – and strategies – in the current economy. *Journal of the American Society on Aging, 43*(2), 71-75.
- Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*(2), 85-94.
- Rural Health Information Hub. (n.d.). *Am I rural?* <https://www.ruralhealthinfo.org/am-i-rural>
- SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). *Six levels of collaboration/integration*. [https://www.integration.samhsa.gov/integrated-care-models/CIHS\\_Framework\\_Final\\_charts.pdf](https://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf)
- Schmit, M. K., Watson, J. C., & Fernandez, M. A. (2017). Examining the effectiveness of integrated behavioral and primary health care treatment. *Journal of Counseling & Development, 96*, 3-14.
- Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proc, 90*(12), 1600-1613. <https://doi.org/10.1016/j.mayocp.2015.08.023>
- Sheldon, G. F. (2011). The evolving surgeon shortage in the health reform era. *Journal of Gastrointestinal Surgery, 15*, 1104-1111.

- Seright, T. J., & Winters, C. A. (2015). Critical care in critical access hospitals. *Critical Care Nurse, 35*(5), 62-67.
- Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, J. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology, 66*(5), 479-489. <https://doi.org/10.1002/jclp.20688>
- Strosahl, K. (1998). Integrating behavioral health and primary care services: The primary mental health care model. In A. Blount (Ed.), *Integrated Primary Care: The Future of Medical and Mental Health Collaboration* (p. 139-166). W. W. Norton & Co.
- United States Census Bureau. (2010). *List of rural counties & designated eligible census tracts in metropolitan counties*.  
<https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/forhpeligibleareas.pdf>
- United States Census Bureau. (n.d.). *Urban and rural areas*.  
[https://www.census.gov/history/www/programs/geography/urban\\_and\\_rural\\_areas.html](https://www.census.gov/history/www/programs/geography/urban_and_rural_areas.html)
- United States Department of Health and Human Services. (2003). Achieving the promise: Transforming mental health care in America. Final report. *DHHS Publication No. SMA-03-3832*. Rockville, MD: New Freedom Commission on Mental Health.
- Vogel, M. E., Kanzler, K. E., Aikens, J. E., & Goodie, J. L. (2017). Integration of behavioral health and primary care: Current knowledge and future directions. *Journal of Behavioral Medicine, 40*, 69-84.
- Wan, S., Teichman, P. G., Latif, D., Boyd, J., & Gupta, R. (2018). Healthcare provider perceptions of the role of interprofessional care in access to and outcomes of primary care in an underserved area. *Journal of Interprofessional Care, 32*(2), 220-223.

- Wang, P., Demler, O., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2006). Changing profiles of services sectors used for mental health care in the United States. *American Journal of Psychiatry*, *163*, 1187-1198. <https://doi.org/10.1176/appi.ajp.163.7.1187>
- Wang, P., Lane, M., Olfson, M., Pincus, H., Wells, K., & Kessler, R. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 629-640.
- Watanabe-Galloway, S., Valleley, R., Rieke, K., & Corley, B. (2017). Behavioral health problems presented to integrated pediatric behavioral health clinics: Differences in urban and rural patients. *Journal of Community Mental Health*, *53*, 27-33. <https://doi.org/10.1007/s10597-016-0024-4>
- Whitlock, E. P., Orleans, C. T., Pender, N., & Allan, J. (2002). Evaluating primary care behavioral counseling interventions: An evidence-based approach. *American Journal of Preventive Medicine*, *22*(4), 267-284. [https://doi.org/10.1016/S0749-3797\(02\)00415-4](https://doi.org/10.1016/S0749-3797(02)00415-4)
- Wong, H., Moore, K., Angstman, K. B., & Garrison, G. M. (2019). Impact of rural address and distance from clinic on depression outcomes within a primary care medical home practice. *BioMed Central Family Practice*, *20*, 123-131. <https://doi.org/10.1186/s12875-019-1015-7>
- Wong, S. L. (2015). Medically underserved populations: Disparities in quality and outcomes. *Journal of Oncology Practice*, *11*(3), 193-194.
- World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice*.

[https://apps.who.int/iris/bitstream/handle/10665/70185/WHO\\_HRH\\_HP\\_N\\_10.3\\_eng.pdf?  
sequence=1](https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HP_N_10.3_eng.pdf?sequence=1)

World Health Organization. (2020). *Coronavirus Disease (COVID-19) pandemic*.

[https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-  
happen](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen)

Yoon, J., Bruckner, T. A., & Brown, T. T. (2013). The association between client characteristics and recovery in California's comprehensive community mental health programs.

*American Journal of Public Health, 103*, 89-95.

<https://doi.org/10.2105/AJPH.2013.301233>

## **Appendix A Informed Consent**

### **Project Title.**

Mental Health Counselors' Perceptions on Preparedness in Integrated Behavioral Healthcare in Rural and Underserved Areas

### **Project Description.**

Many residents in rural, healthcare provider shortage (HPS), and medically underserved (MU) areas in the U.S. continue to experience adverse challenges regarding their healthcare, care services, and resources. Integrated behavioral and primary healthcare (IBPH) model has been suggested and proved to be a cost-effective approach in improving access to and quality of healthcare in rural and underserved communities. The purpose of this study is to explore mental health counselors' perceptions on their educational preparedness in IBPH settings, specifically in regard to working with rural, HPS, and MU communities.

### **Project Investigators.**

Jeff Moe, Ph.D., LPC, NCC, CCMHC is an associate professor in Counselor Education & Supervision at Old Dominion University. Dr. Moe is the principal investigator of this project.

Kyulee Park, M.Ed., Resident in Counseling (VA) is a PhD candidate in Counselor Education & Supervision at Old Dominion University. This qualitative study is part of researcher's doctoral dissertation.

### **Participation Process.**

Participants in this study will be invited to an in-person or a virtual interview with the researcher. Participants will be asked some basic information on demographic, educational, and professional background as well as questions regarding perceptions and experiences regarding integrated behavioral and physical healthcare in rural, medically underserved, and healthcare provider shortage areas. The interview will take from 45 to 60 minutes. After the interview, participants will be asked to practice expressive writing (journaling) for a week on the topics of integrated behavioral healthcare, underserved and underprivileged populations, and educational/training needs. Completed journal entries will be submitted to the researcher for analysis.

### **Risks and Benefits.**

There is no foreseeable risk associated with participating in this study. The anticipated benefit of your participation in this study is increased awareness and knowledge in IBPH in rural, medically underserved, and healthcare provider shortage areas as well as contribution to future development of interprofessional education for mental health counseling professionals.

### **Confidentiality.**

All records from this study will be kept as confidential as possible. No personally identifiable information will be used in any reports or publications resulting from the study. All audio recordings, researcher notes, transcription demographic questionnaire, and informed consent documents will be given codes and/or stored separately from any names or other personally identifiable information of participants. Only research personnel will have access to the

aforementioned documents. Once the audio recordings are transcribed, all recordings will be properly destroyed. After the study is completed, all collected data will be properly destroyed.

*\*Participants will be given an opportunity to select and use a pseudonym prior to the audio recording.*

**Withdrawal Privilege.**

You can withdraw your consent and/or discontinue participation in the study at any time without prejudice or consequences. You have the right to decline to answer any questions or discuss any topics without any consequences during the study.

**Contact Information.**

Should you have any questions or concerns regarding this study, please contact Kyulee Park, project investigator, at [kpark012@odu.edu](mailto:kpark012@odu.edu), Dr. Jeff Moe, project investigator's dissertation chair at [jmoe@odu.edu](mailto:jmoe@odu.edu), or Dr. Laura Chezan, the Chair of Human Subjects Review Committee at Old Dominion University Darden College of Education & Professional Studies at [lchezan@odu.edu](mailto:lchezan@odu.edu) or 757-683-7055.

**Voluntary Consent.**

I have read this document and understand the purpose of the study, its risks and benefits, and my rights. By signing this form, I agree to participate in this study and to be audio-recorded.

---

(Participant Signature)

---

(Date)

---

(Researcher Signature)

---

(Date)

## **Appendix B Individual Interview Protocol**

### **Participant Recruitment**

- Recruit eight participants via purposeful, convenience, and snowball sampling methods
- Distribute recruitment emails via listservs such as CESNET
- Contact interested participants by telephone or email to explore interest level and appropriateness of candidate

### **Description of the Study and Informed Consent**

- Provide a description of the study and consent form via email or in person
- Request that the participants allocate at least 45 to 60 minutes for scheduled individual interviews
- Review and receive consent form signed by participants
- Answer any questions participants may have about the study and their participation

### **Individual Interview**

- Receive written consent prior to interview
- Receive verbal consent for participants to review the transcription of the interview for accuracy and clarification during the data analysis process
- Conduct a one-on-one in-person or virtual interview during January through February of 2020. Interviews will be conducted by the primary researcher and will last approximately 45 to 60 minutes
- Audio record interviews

- All recordings will be password-protected and destroyed once transcription is completed.

### **Script to Participants**

Thank you for taking the time to participate in this study. I appreciate your input and insight, and your participation is a valuable part of this study. (Interviewer will review consent form with the participant). Now that we have reviewed the consent form, please feel free to let me know if you have any questions or concerns regarding this study or your participation.

As you have read, I will be asking a series of questions related to your educational and professional experiences and perceptions regarding your practice in integrated behavioral and primary healthcare settings, serving rural, healthcare provider shortage, and medically underserved communities. There are no right or wrong answers, and your candid input will be greatly appreciated. Any personally identifiable information will be connected to your data or published in any format.

We will be recording the interview, which will last approximately 45 to 60 minutes. Should you wish to end the interview sooner or decline to answer a question, please feel free to do so. The audio recording will be transcribed and destroyed once the transcription is complete. I will take reasonable measures to ensure your confidentiality.

Before we begin, would you like to select a pseudonym to use for the purpose of this study?

If there are no further questions, I am going to turn the recorder on now.

### **Semi-Structured Interview Questions**

- What does it mean to practice as a mental health counselor in an integrated behavioral and primary care setting?

- What does it mean to practice as a mental health counselor in an IBPH setting, specifically serving rural, healthcare provider shortage, and medically underserved areas?
- What aspects or experiences of rural/HPS/MU IBPH practice did you find most salient?
- What aspects or experiences of rural/HPS/MU IBPH practice did you find most challenging?
- In what ways did your CACREP program prepare you to practice in an IBPH setting?
- In what ways did your CACREP program prepare you to practice in rural, healthcare provider shortage, and medically underserved communities?
- What do you wish that your CACREP program had included in its curriculum to prepare you as an IBH practitioner in underserved areas?

### **Post-Individual Interview**

- Request that the participants engage in a week of personal journaling (expressive writing) about their thoughts, feelings, and experiences associated with their IBPH practice in rural, healthcare provider shortage, and medically underserved communities
- Request that the participants complete the journaling within two weeks of the interview and return to the primary researcher
- Request that the participants review their own interview transcripts for accuracy

## **Appendix C Personal Journaling Protocol**

### **Personal Journaling Procedure**

- Request that the participants engage in a week of personal journaling (expressive writing) about their thoughts, feelings, and experiences associated with their IBPH practice in rural, healthcare provider shortage, and medically underserved communities
- Request that the participants complete the journaling within two weeks of the interview and return to the primary researcher
- Email participants the Personal Journaling Script

### **Personal Journaling Script**

Thank you very much again for participating in this study. Your input and insight are greatly appreciated. I would like to ask you to complete a personal journal reflecting on your IBPH practice in rural, healthcare provider shortage, and medically underserved communities for a week. It is preferred that the journal is completed in Microsoft Word; however, a hand-written journal will be acceptable as well. I would like you to email me the journals in an attachment to [kpark012@odu.edu](mailto:kpark012@odu.edu) within two weeks of our individual interview completion date. All received materials will be kept confidential and any personally identifiable information will be redacted. All received materials will be properly destroyed after data analysis is completed.

Please complete this within two weeks of the interview. You may spend as little or as much as time as you would like each day journaling, for a week (i.e., 5 workdays). Please reflect on the following prompts, including but not limited to:

- Specific educational or training needs or topic areas that you have encountered in rural/HPS/MU IBPH settings

- Specific supervision needs or topic areas that you have encountered in rural/HPS/MU IBPH settings
- Multicultural counseling/supervision and/or social justice issues that you have encountered in rural/HPS/MU IBPH settings
- Professional identity issues that you have encountered in rural/HPS/MU IBPH settings
- Ethical concerns that you have encountered in rural/HPS/MU IBPH settings

**Appendix D**  
**Table of Themes and Subthemes**

Themes	Definitions	Subthemes	Examples
Multitude of Therapist Roles in IBH	Experience with assuming multiple roles in IBH that extends the boundaries of traditional counseling	Client Psychoeducation	“Kind of anything that could be seen as a potential behavioral health concern. So, if they have hypertension, I'm really look working on like breathing techniques, mindfulness, things like that.”
		Professional/Staff Psychoeducation	“And he said the first couple of weeks what my real job was to be, to just build relationships with the physicians because they were going to need to know me if they were going to utilize me.”
		Client/Patient Advocacy	“A lot of times our clients in group or an individual will express medication concerns to us, [...] but they don't always feel supported in doing that. We also have to advocate on behalf of the clients if medication needs to be adjusted.”
		“Translation”	“To see the light bulb, to see the doctor trying to explain this thing and then to translate it, and to see the light bulb click for the patient/client, was really powerful and it was something that you don't really get to experience in the regular normal counseling arena.”
		Solution-Focused Consultation	“I get to come in and problem solve and be like, “well, they're not showing up because they don't have any bus passes. Can you guys give them some bus passes, or can we help them figure out a way to get here?””
		Flexibility/ “Multiplayer”	“I think in an integrated setting, even if you are a counselor, I think your role is still a little more, it's still kind of multiple roles versus at a private practice [...] You're a case manager or sometimes you're a family therapist. It just kind of, you have multiple roles, I think.”
Identified Benefits of IBH	Clear advantages that are specific and unique to integrated behavioral and primary healthcare	Convenience of Co-located Services	“The idea is to make it as easy as possible to get all these services so they can see their doctor, they can see their case manager, they can see their psychiatrist, they can see their counselor, and they can get their prescription all in one place, all in the same day.”
		Holistic & Client-Centered Approach	“It's been a really good experience because I think you get to see clients come in and have support in all aspects.”
		Burnout Prevention / Shared Responsibilities	“I think in some way, even though the demand is still high, like we still have more clients asking for services than we can provide at times, I feel far less burnt out because I think the integrated approach actually helps us practitioners. We are getting support from different colleagues with different perspectives.”
		Increased Introspection & Reflexivity	“If anything, that challenge will just lead me to reflect deeper on, “well, why is it that I'm inclined to do it the way I'm inclined to do it” and to get me to reflect on it more.”
		Interprofessional Learning & Growth	“Conversations with [PCPs and psychiatric nurse practitioners] have allowed me to have more insight and awareness of how some of the factors that impact the client's daily wellbeing [...] It's been really helpful having those practitioners around, particularly to collaborate on the care of individuals.”

Themes	Definitions	Subthemes	Examples
Barriers to Integration/ MUA Care	Barriers to successful integration of healthcare practices and effective medically underserved population healthcare	Lack of Resources & Accessibility  Decreased Applicability of Counseling Theories  Level of Integration / Site Commitment  Lack of Understanding in Professional Responsibilities	<p>“They don't have access to care, so they don't necessarily know what kind of help they need.”</p> <p>One difference that I noticed was the applicability and transferability of career counseling as it was taught to me. In working with clients that lived in rural areas and in poverty, many of the ideas of workplace preferences, personality, and taking a developmental approach to career development that I learned in my master's program seemed like a privileged approach to integrating career counseling into my work.</p> <p>“Consequences of things not being completely integrated. [...] I guess one thing that I found really challenging was the lack of communication piece.”</p> <p>At times, it felt as if some of the clients that were referred to me could have been referred to other professionals within the agency that had greater expertise in certain areas than I did.</p>
IBH Professional Identity Development	Professional identity development processes and values that are specific to integrated behavioral and primary healthcare	Counselor Identity Development  Counseling Profession Advocacy  Promotion of IBH Awareness & Integration  Understanding Differences in Professions	<p>“I think being able to bring counselor culture into the medical culture was good overall for everyone involved. [...] I think it's very important to retain your identity as a counselor, because that's what we're taught is to be soothing, be comforting, be personal and professionally personable.”</p> <p>“I spent a lot of time trying to educate people on the different mental health degrees and helping them understand the scope of my practice.”</p> <p>“I think that these integrated behavioral health practices are going to be a really great opportunity to grow our field.”</p> <p>“I'm explaining my role to them and then also learning the differences between a nurse practitioner and a PA, or a DO and an MD, and how they might utilize me differently.”</p>
Educational & Training Needs	Identified educational and training needs in counselor education for effective preparation of IBH practitioners	Foundations of Counseling  IBH Awareness & Exposure  On-the-Job Learning  Evidence-Based Techniques for Specialty Care	<p>“I guess multicultural classes, they seem like they were helpful in emphasizing an attitude of humility and curiosity.”</p> <p>“I think that it should be brought up in a master's program, at least the fact that it's out there and it's something that's becoming more popular. And so maybe prepare yourself for that.”</p> <p>“I didn't have any exposure to really until I was in the IBH setting. I learned it on the job.”</p> <p>“I could probably use more training in ways to address clients with co-morbid physical illness. For example, is it okay to use progressive muscle relaxation with someone who has chronic pain? or is there adapted deep breathing for individuals with asthma?”</p>