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Supervision Needs of Novice Behavioral Health Providers in Integrated Primary Care Settings: A Delphi Study

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SUPERVISION NEEDS OF NOVICE BEHAVIORAL HEALTH PROVIDERS IN INTEGRATED PRIMARY CARE SETTINGS: A DELPHI STUDY

by

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ABSTRACT

Supervision Needs of Novice Behavioral Health Providers in Integrated Primary Care Settings: A Delphi Study

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The integration of behavioral health providers (BHPs, i.e., clinical mental health counselors, clinical psychologists, clinical social workers, marriage and family therapists) into primary care settings has developed as a healthcare practice associated with enhanced patient clinical outcomes, enhanced patient satisfaction, reduced healthcare expenditures, and enhanced provider wellness and satisfaction, known together as the Quadruple Aim. For BHPs practicing in integrated primary care (IPC) settings, researchers have highlighted a variety of challenges they experience when integrating in these settings, with a consistent challenge being a lack of satisfactory training and supervision. Clinical supervision has been hailed as the "signature pedagogy" for behavioral health professions (Bernard & Goodyear, 2019, p. 2), highlighting the importance for BHPs to be provided with adequate supervision for effective practice in IPC settings. The purpose of this study was to explore the supervisory needs of novice BHPs in IPC settings. In this study, I used a Delphi methodology to achieve consensus on what novice BHPs perceive to be their pertinent supervisory needs as they navigate clinical practice and professional development in IPC settings. The results indicated a list of 68 statements that a group of expert panelists indicated to be the supervisory needs of novice BHPs in IPC settings. These statements were categorized into nine themes: 1) *The Supervisory Experience*; 2) *Supervisor Characteristics*; 3) *Supervisor Knowledge & Training*; 4) *Interdisciplinary Training*;

5) *Medical Training*; 6) *Clinic-Specific Orientation*; 7) *Clinical Training*; 8) *Professional Development*; and 9) *Additional Supervisory Needs*. The findings of this study have implications for current supervisors in IPC settings, novice BHPs in IPC settings, and behavioral health educators.

This dissertation is dedicated to all the individuals who have loved, cared for, and supported me over the years. You all mean the world to me, and I would not be here without you.

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CHAPTER ONE

INTRODUCTION

In this chapter, I will explore the context, purpose, and significance of the current study. Next, I will provide a brief overview of the conceptual framework and methodological design, including the research question. Finally, I will provide operational definitions for terms that are used throughout the research.

Context of the Study

Since the 1980s, there has been a call for a biopsychosocial conceptualization of health and wellness, acknowledging the interrelatedness of physical, psychological, and social wellbeing on overall health (Engel, 1980). Integrated Behavioral Health (IBH), a model of care emphasizing the active integration of behavioral health professionals in medical settings towards the goal of holistic and collaborative care between medical and behavioral health providers (Academy for Healthcare Research and Quality [AHRQ], 2023; O'Donohue, 2018), has been a response to this call for whole-person care. Within this model, behavioral health providers (BHPs; i.e., clinical mental health counselors, clinical psychologists, clinical social workers, marriage and family therapists) work collaboratively with medical providers (e.g., primary care providers, nurses, medical assistants), care enhancers (e.g., case managers, social workers), and administrative staff to provide care that spans a variety of medical and clinical or sub-clinical behavioral health concerns (Blount et al., 2017). The effects of an IBH delivery model have been multidimensional, spanning beneficial clinical (Chen et al., 2021; Powers et al., 2020; Schmit et al., 2018; Ulupinar et al., 2021; Wells et al., 2018), financial (Peterson et al., 2017; Ross et al., 2019; Wells et al., 2018), and professional (Berkel et al., 2019; Miller-Matero et al., 2016; Zubatsky et al., 2020) outcomes. However, a common concern for BHPs are challenges related

to training opportunities for IBH settings, spanning avenues such as coursework in graduate education programs (Dice et al., 2022; Li et al., 2022) and clinical supervision in IBH settings (Li et al., 2022; Ogbeide et al., 2023a).

BHPs often fulfill a variety of roles and responsibilities in IBH settings (Glueck, 2015) and may need to adapt to the culture and skillset of IBH (Robinson & Reiter, 2016). These factors may often deviate significantly from the specialty mental health model typically taught in behavioral health training programs. Prior researchers have highlighted a variety of challenges new BHPs face when transitioning into IBH settings, including a lack of clarity in their roles and responsibilities, difficulty adapting to the culture and constraints (e.g., time, space) of the medical site, ineffective interdisciplinary communication, insufficient training, and difficulty navigating administrative and systemic concerns (Asempapa, 2019; Berkel et al., 2019; Dice et al., 2022; Li et al., 2022; Prom et al., 2021). A significant contributor to these challenges may be related to a dearth of effective clinical supervision. In a study focusing on challenges faced by counselors in IBH settings, over half of all participants indicated that they did not receive supervision that met their needs (Li et al., 2022). This highlights a significant issue, as supervision in the behavioral health professions is conceptualized as the "signature pedagogy" (Bernard & Goodyear, 2019, p. 2).

Clinical supervision has been conceptualized as a hallmark of training for BHPs, transcending professional identities, roles, and responsibilities (Bernard & Goodyear, 2019). Within this process, more experienced professionals provide intentional guidance, teaching, consultation, and support to enhance the professional development and effectiveness of more novice professionals, conceptualized as supervisors (SORs) and supervisees (SEEs), respectively (Bernard & Goodyear, 2019; Corey et al., 2021). As IBH becomes more prevalent, particularly

in primary care settings (Richman et al., 2020), it becomes important that effective, competent supervision tailored to IBH is provided for clinicians (Edwards & Patterson, 2006; Ogbeide et al., 2023a; Pratt & Lamson, 2011; Ogbeide et al., 2023b). While competencies and best practices for counseling SORs (Neuer Colburn et al., 2015; Borders et al., 2014) and skills and competencies for SORs in primary care settings (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023) have been identified by prior researchers, the specific supervisory needs of internship students in IBH settings from their perspective is a current gap in the IBH supervision literature.

Due to the importance of clinical supervision in the personal and professional development of behavioral health professionals (Bernard & Goodyear, 2019; Corey et al., 2021), it is an imperative that behavioral health internship students receive effective clinical supervision as they initially navigate clinical practice in an IBH setting. Prior researchers have identified common components of effective clinical supervision through SOR competencies (Neuer Colburn et al., 2015) and best practices endorsed by the Association for Counselor Education and Supervision (Borders, 2014; Borders et al., 2011; Borders et al., 2014). Pertaining to clinical supervision in IBH settings, researchers have highlighted the important skills, considerations, and competencies for providing effective supervision in these environments (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023). While these guidelines and competencies promote SOR competence, they may not guarantee that clinical SORs are meeting the unique needs of novice clinicians in IBH settings.

As medical settings are increasingly addressing the call to integrate BHPs into their workflow and systems (Hunter et al., 2018b; Richman et al., 2020), ensuring clinicians are properly trained and supervised becomes vital for the success of these programs. Given the importance of supervision in the professional development of BHPs (Bernard & Goodyear,

2019), SORs in IBH settings will need to understand the supervisory needs of novice clinicians as they integrate into these settings and the profession. Through greater clarity on what novice clinicians in IBH settings perceive to be their most pertinent needs in supervision, SORs can better structure and prepare them to meet the need of the evolving healthcare system.

Purpose of the Study

As previously stated, prior researchers have indicated that BHPs in IBH settings have identified unsatisfactory supervision as a primary contributor to challenges practicing in these settings (Li et al., 2022). This highlights a significant issue in the preparation of behavioral health providers in primary care, as primary care has been identified as one of the main settings in which individuals receive behavioral healthcare (Kessler & Stafford, 2008). Inadequate supervision may contribute to issues in clinical effectiveness, workforce development, and enhancement of the primary care system. These issues may have widespread consequences because of supervision that does not adequately provide novice BHPs with the tools and skills needed to succeed in integrated primary care settings. Therefore, in this study, I explored the perceptions of novice BHPs' supervisory needs as they practice in integrated primary care settings to complement our understanding of supervision established through other stakeholders (e.g., Neuer Colburn et al., 2015; Ogbeide & Bayles, 2023; Pratt & Lamson, 2011). The purpose of this study was to examine the wide range of novice clinicians' supervisory needs (e.g., relational, clinical, educative, consultative) when receiving clinical supervision in integrated primary care.

Significance of the Study

As a result of this study, clinical SORs in integrated primary care settings will have a framework for structuring, delivering, and evaluating the effectiveness and practicality of

supervision in traditional medical settings with BHPs integrated into the system. This structure may allow for SORs to plan and conceptualize SEEs in integrated primary care settings by more effectively anticipating and addressing commonalities that new primary care BHPs may share. Additionally, novice clinicians in new settings may rely highly on their didactic training as an anchor for clinical work; however, behavioral health services within the primary care context may deviate significantly from traditional specialty mental health models typically taught in behavioral health training programs. If SORs have a general sense on the needs of novice clinicians, they may be better equipped to prepare them for the nuances of behavioral health care in primary care. Additionally, this study's results may provide SORs with a framework for evaluating the effectiveness of clinical supervision, having a specific set of needs identified by a group of experts to be pertinent for novice clinicians as they transition into integrated primary care settings.

Specifically for counselor educators and SORs, results may allow for counselors to cement themselves as vital clinical and supervisory members of integrated primary care settings, given the history of clinical psychologists and social workers as the primary behavioral health providers in IBH settings (Lloyd-Hazlett et al., 2020). Counselor educators may also use this information to enhance the preparation of counselor trainees for practice in integrated primary care settings, allowing for them to use clinical supervision as a supplement to their didactic training.

As a result of this study, behavioral health SORs in primary care settings may ultimately enhance the provision of clinical supervision and the preparation of novice clinicians for independent practice in IBH settings, potentially contributing to higher provider and patient

satisfaction, more effective primary care systems, and more successful clinical behavioral health interventions within the primary care context.

Overview of Conceptual Frameworks

I will approach this research from both social constructivist and postpositivist perspectives (Creswell & Creswell, 2018). The social constructivist paradigm perceives individual reality as grounded in the lived experiences of individuals within the context of their social relationships and interactions (Boyland, 2019; Creswell & Creswell, 2018). Knowledge is constructed based on the ways in which an individual interacts with themselves, peers, their community, and greater social contexts. Due to the subjective nature of individual reality, social constructivism is an ideal perspective for approaching qualitative components of research (Dawadi et al., 2021), allowing for participants' lived experiences and perceptions to be highlighted throughout the research process. In the context of this study, the social constructivist perspective will allow me to conceptualize novice BHPs' supervisory experiences and needs as influenced by their lived experiences and social interactions.

Postpositivist paradigms conceptualize knowledge as speculative, in which absolute truth is unobtainable (Creswell & Creswell, 2018; Panhwar et al., 2017). Additionally, this perspective acknowledges the benefits of a variety of methods to explore the research questions (Dawadi et al., 2021; Panhwar et al., 2017). This may allow for quantitative data to be conceptualized within the circumstances of the participants and the research, promoting a contextual understanding of narrative and numerical data. In the context of this study, the postpositivist perspective will allow me to conceptualize statistical consensus as grounded in the idea that truth is not concrete and is influenced by the individual and their contexts. Therefore, the intersection of the social constructivist and postpositivist perspectives in this study will lead me to understand the

consensus achieved by expert panelists as an intricate interconnection between objective and subjective, influenced by expert panelists' perceived truth, lived experiences, and social interactions with others (e.g., themselves, other panelists, SORs).

Research Question

The research question of the study will be as following: What do novice behavioral health providers in Integrated Primary Care settings identify to be their most pertinent needs in clinical supervision?

Research Design

For this study, I propose the use of an exploratory-sequential mixed methods design, the Delphi methodology (Creswell & Creswell, 2018; Linstone & Turoff, 1975), to address the research question. The Delphi methodology is an ideal design for gathering the expertise of the panelists to explore topics that have a limited literature base, are not appropriate for complex statistical analyses, or are undefined or disputed (Grisham, 2009; Iqbal & Pipon-Young, 2009; Strear et al., 2018). This research design uses various rounds of structured, anonymous questionnaires to explore expert panelists' perceptions of the topic through qualitative analysis and to achieve consensus on generated statements through quantitative analysis (Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009). In this proposed study, expert panelists will engage in indirect communication to come to consensus on what they perceive to be the most pertinent needs of novice BHPs receiving clinical supervision in IBH settings.

Operational Definitions of Terms Throughout the Study

Behavioral Health

A broad concept within health and wellness that encapsulates the wide range of behavioral, emotional, and mental health considerations towards biopsychosocial wellness (e.g.,

mental health condition, substance use, health behaviors; Academy for Health Research and Quality [AHRQ], n.d.; Peek & Council, 2013).

Behavioral Health Provider

Behavioral health providers (BHPs) are professionals who engage in a variety of roles in IBH settings, which may include behavioral health screening and intervention, consultation, education, program administration and development, research, and/or referral coordination (Glueck, 2015). For this study, BHPs will come from at least one of the following professional identities: clinical mental health counseling, clinical psychology, clinical social work, and/or marriage and family therapy (Blount et al., 2017; Ward et al., 2023). In the Primary Care Behavioral Health (PCBH) model, BHPs are referred to as Behavioral Health Consultants (BHCs; Robinson & Reiter, 2016). In the Collaborative Care Model (CoCM), BHPs are referred to as care managers (American Psychiatric Association, n.d.).

Clinical Supervision

Clinical supervision is defined as both an intervention and relationship in which a more experienced member of a profession provides direct teaching, consultation, mentorship, counseling, and evaluation to a more novice member of a profession to enhance their preparation for independent practice and protect the integrity of the profession (Bernard & Goodyear, 2019; Corey et al., 2021).

Clinical Supervisor

A clinical supervisor is the more experienced member of a profession within the concept of clinical supervision, providing a range of interventions related to the clinical, administrative, and developmental growth of a less experienced member of a profession (Bernard & Goodyear, 2019; Corey et al., 2021). In this study clinical SOR may be a master's or doctoral-level licensed

behavioral health professional who is supervising independently or an advanced, doctoral-level trainee of a profession who is receiving supervision of their supervision practice.

Clinical Trainee/Supervisee

A clinical trainee/supervisee is the more novice member of a profession within the concept of clinical supervision, being the recipient of supervisory interventions and active participant within the supervisory process and outcomes (Bernard & Goodyear, 2019; Corey et al., 2021). A clinical trainee/supervisee can be an individual who is currently receiving individual or triadic supervision while being a current graduate student seeking a degree in a master's or doctoral level behavioral health clinician training program. For the purposes of this study, clinical trainees/supervisees are simultaneously conceptualized as novice clinicians due to personal and professional characteristics indicative of requiring additional professional support from a more experienced member of a profession prior to independent practice.

Collaborative Care

Collaborative care is a broad understanding of healthcare practice emphasized by active, ongoing interprofessional relationships and teamwork towards comprehensive treatment (Peek & Council, 2013). The distinction is made that collaborative care is conceptualized as working with other healthcare professionals in general, rather than working collaboratively with other healthcare professionals in a setting where they are integrated into the system (Center for Psychology and Health, 2017). This spans levels of integration ranging from coordinated, co-located, and integrated (Fiscella & McDaniel, 2018; Heath et al., 2013). Collaborative care (CC) is distinct from the Collaborative Care Model (CoCM), in which CC is a general conceptualization of collaboration in healthcare while the CoCM is a specific model of care (Center for Health and Psychology, 2017).

Expert Panelist

Expert panelist is the language used in Delphi studies to describe the participants who make up the Delphi panel, generate statements, and engage in structured communication with each other to reach consensus on the topic(s) of interest (Iqbal & Pipon-Young, 2009). Expert panelists are conceptualized as individuals who meet minimum criteria developed for experts in the topic(s) under investigation. In this study, these criteria are as follows: 1) being a behavioral health professional in training (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education; having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting; and 3) having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting.

Integrated Behavioral Health

Integrated behavioral health (IBH) is a term that is often used interchangeably with integrated care (IC) and integrated health care (IHC). IBH is conceptualized as a model of healthcare in which behavioral health clinicians (e.g., clinical mental health counselors, clinical psychologists, clinical social workers, and/or marriage and family therapists) work alongside medical (e.g., primary care providers, specialty physicians) and other healthcare (e.g., care enhancers) professionals in a shared setting to comprehensively address patients' biopsychosocial health concerns (AHRQ, n.d.; AHRQ, 2023; Blount et al., 2017). IBH is typically situated within primary care and specialty medical settings (AHRQ, n.d.) and occurs

through integrated treatments, programs, systems, and payment methods (Heath et al., 2013; Peek & Council, 2013).

Integrated Behavioral Health Setting

An IBH setting is conceptualized as a traditional medical setting in which behavioral health clinicians are actively integrated to provide behavioral health care as part of an interdisciplinary care team. This may include primary care clinics (e.g., community, private, pediatric), specialty medical clinics (e.g., oncology, cardiology, obstetrics and gynecology), and/or acute and emergency medical settings (e.g., general hospitals, emergency departments, urgent care clinics). For this study, IBH settings will be focused on primary care clinics (AHRQ, n.d.).

Integrated Primary Care

Integrated primary care (IPC) is a type of IBH in which there is the active integration of behavioral health clinicians within a primary care setting with medical providers (i.e., primary care physicians), medical support staff (e.g., medical assistants, nurses), and other staff (e.g., office managers). IPC occurs within the context of the primary care setting and may include the Primary Care Behavioral Health (PCBH) model (Hunter et al., 2018b; Reiter et al., 2018), Collaborative Care Model (CoCM; Unützer et al., 2002; Unützer et al., 2013), or a blended PCBH-CoCM approach (Hunter & Goodie, 2010).

Novice Clinician

Novice clinicians are conceptualized as individuals who are in the early stages of their professional development and identity as a behavioral health clinician. Novice clinicians often hold similar characteristics, including a reliance on declarative knowledge (Kemer, 2020), patterns of thinking and behaving indicative of a Level 1 SEE within the Integrative

Developmental Model (Corey et al., 2021; Stoltenberg & McNeill, 2010), and limited direct clinical experience (Marmarosh et al., 2013). For this study, novice clinicians are understood as behavioral health clinicians completing supervised clinical hours as a part of their internship or providing uninterrupted supervised clinical services no more than six months after graduation while under the supervision of a clinical SOR. Clinical trainees/supervisees are conceptualized as novice clinicians in this study.

Primary Care

According to Peek and Council (2013), primary care is the provision of comprehensive care that is readily accessible and addresses the wide range of biopsychosocial concerns that the general population may experience through a longitudinal relationship with patients, families, and communities. Within the context of primary care, there are four core functions, often conceptualized as the 4Cs: 1) first contact to healthcare services when needed; 2) comprehensiveness in the treatment available; 3) coordination of the wide range of biopsychosocial healthcare services needed that may be outside of the scope of primary care or better addressed in a specialty setting (e.g., cardiology, specialty mental health); and 4) continuity of care that is longitudinal in nature (Jimenez et al., 2021; Starfield, 1994). The core distinction between traditional and integrated primary care is the integration of behavioral health professionals as members of the primary care team.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, I will first present an introduction to Integrated Behavioral Health (IBH) in primary care, including rationale and current trends for this model of healthcare. Next, I will provide an in-depth exploration of the models and types of behavioral health integration in primary care, the benefits of primary care IBH as they relate to the Quadruple Aim, and the unique training needs of clinicians in these settings. After that, I will explore the process of clinical supervision, emphasizing the literature on supervision of BHPs in primary care settings. Finally, I will finish this chapter by providing the context and research questions of this study.

Behavioral Health Integration in Primary Care

Researchers have identified the high prevalence of behavioral health concerns presenting in traditional medical settings, including general hospitals (Rayner et al., 2014) and primary care clinics (Roca et al., 2009). The connection between behavioral and physical health has been well documented, with significant evidence of the comorbidity between behavioral health concerns and chronic health conditions (Bahorik et al., 2017; Koball et al., 2019; Sporinova et al., 2019; Yohannes et al., 2010). Behavioral health dimensions have been identified in various medical conditions, including cardiovascular disease (Chaddha et al., 2016), cancer (Kuhnt et al., 2016), chronic pain (Darnall, 2019), obstructive lung disease (Spitzer et al., 2011), diabetes (Butkiewicz et al., 2016), and obesity (Lawrence & Abel, 2016). These comorbidities are likely bidirectional (Walker & Drugg, 2016). The consequences of comorbid biopsychosocial health concerns are far-reaching and may include poorer patient quality of life (Baumeister et al., 2011; Chiang et al., 2021), increased utilization of emergency healthcare services (Koball et al., 2019), and increased healthcare expenditures (Su et al., 2016).

Primary care has been identified as one of the first settings individuals seek behavioral health services from (Kessler & Stafford, 2008). Researchers have found patients are increasingly incorporating behavioral health concerns into their primary care visits, rising from 10.7 to 15.9 percent of visits from 2006 to 2016 (Rostenstein et al., 2023). In response to the behavioral health needs of patients in traditional medical settings, a variety of stakeholders in the healthcare system have advocated for the integration of BHPs into primary care. In IBH systems, a wide range of healthcare professionals engage in collaborative care through institutional policies and practices that integrate treatment, structural, programmatic, and financial components (Heath et al., 2013; Hoge et al., 2014; Peek & Council, 2013).

IBH in primary care is growing in the United States (U.S.), with researchers indicating that the rate of primary care physician/provider (PCP) colocation with behavioral health providers has been increasing, particularly in urban areas (Richman et al., 2020). Currently, there are various government agencies (e.g., Agency for Healthcare Research and Quality, Health Resources and Services Administration) and professional organizations (e.g., Collaborative Family Healthcare Association, Society for Health Psychology) advocating for the advancement of integrated care, highlighting levels of support for increasing the prevalence and effectiveness of IBH initiatives. Prior researchers have also highlighted the need for ongoing dissemination of research and knowledge related to IBH in primary care, allowing for continued growth and development of this specialization (Hunter et al., 2018b; Vogel et al., 2017).

In this approach, behavioral health services in primary care emphasize health promoting behaviors, prevention of mental health symptoms and diagnoses, and strengthening protective factors (Talen & Valeras, 2013). This includes evidence-based interventions oriented towards behavioral health concerns that are diagnosable (e.g., Major Depressive Disorder, Generalized

Anxiety Disorder), as well those that are subclinical and not indicative of a formal diagnosis (e.g., treatment nonadherence, generalized stress; Peek & Council, 2013; Serrano et al., 2018) Additionally, BHPs in primary care often fulfill roles beyond providing direct psychotherapy, including consultant, educator, program administrator, program developer, and referral coordinator to serve the patient, providers, and clinic (Berkel et al., 2019; Glueck, 2015).

An important consideration for the implementation of IBH services in established primary care clinics is to critically conceptualize IBH within the site's context (Prom et al., 2021; Reiter et al., 2018; Vogel et al., 2017), tailoring the various integrated components highlighted by Peek and Council (2013) to match the needs of the setting, providers, and patients. Currently, there are various models, levels, and types of integration which serve as guidelines for the conceptualization and development of integrated primary care (IPC) services. The ways in which primary care clinics integrate behavioral health into their preexisting systems has implications for the ways in which these programs have been developed, implemented, and evaluated, as well as ways in which BHPs are trained and supervised.

Integrated Primary Care Models

Within the IBH literature, two models of behavioral health integration in medical settings that have received significant attention (Hunter et al., 2018a): the Primary Care Behavioral Health (PCBH) model (Hunter et al., 2018b; Reiter et al., 2018) and the Collaborative Care Model (CoCM; Unützer et al., 2002; Unützer et al., 2013).

Primary Care Behavioral Health

PCBH is a model of IBH in which BHPs integrate into primary care clinics as a core provider to address behavioral health needs of the primary care population (Hunter et al., 2018b; Reiter et al., 2018; Robinson & Reiter, 2016). In this model of care, BHPs are conceptualized as

Behavioral Health Consultants (BHCs), and their services are meant to enhance the primary care services provided by PCPs rather than serving as a traditional therapist (Robinson & Reiter, 2016). In this process, BHCs in the PCBH model often see a high volume of patients per day in focused, 30-minute sessions in the primary care clinic, frequently relying on same-day consultations and warm-handoffs to enhance the accessibility of behavioral health services (Hunter et al., 2018b; Reiter et al., 2018). Figure 1 provides an overview of important dimensions of the PCBH consultant role as distinct from the traditional specialty mental health therapist role. Core competencies for behavioral health consultants in the PCBH model span multiple domains, including targeted intervention, pathway services, documentation, consultation, team performance, practice management, and administrative knowledge skills (Robinson & Reiter, 2016).

Figure 1

Consultant versus Therapist Dimensions from Robinson and Reiter (2016, p. 15)

Dimension	Consultant	Therapist
Primary consumer	PCP	Patient/client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	PCP	Therapist
Referral generation	Results-based	Independent of outcome
Productivity	High	Low
Problem scope	Wide	Narrow/specialized
Termination of care	Patient progressing toward goals	Patient has met goals

Clinicians, researchers, and leaders often conceptualize consultants in PCBH through the *GATHER* acronym (Reit15er et al., 2018). From this perspective, behavioral health consultants are *Generalists*, providing care to the entirety of the primary care population regardless of biopsychosocial presentation; they are *Accessible*, providing same-day and expedited access to behavioral health to enhance primary care systems; they are *Team-Based*, working in tandem

with the primary care team as a core provider; they have *High-Productivity*, providing behavioral health appointments to a large portion of primary care patients; they are *Educators*, seeking to enhance the effectiveness and understanding of behavioral health services to the primary care team; and they are part of *Routine* care, promoting the idea that behavioral health is an important component of biopsychosocial health that holds similar importance as biomedical concerns (Reiter et al., 2018). Using this acronym, new and experienced BHCs in primary care settings have a template for how to best practice within this model of behavioral health integration.

Within the PCBH model, the goal is "improving primary care services for the whole clinic population; not for a specific condition or specific patients or a specific sub-group of the larger population" (Reiter et al., 2018, p. 118). Within this overarching goal, there are two important dimensions. First, the PCBH model seeks to enhance primary care services being offered, allowing biopsychosocial healthcare to be delivered in a way that benefits all patients, including those who are and who are not seen by the behavioral health consultant (Hunter et al., 2018b). Additionally, this model of care was generated to promote population health rather than individual health, ensuring that behavioral health services remain accessible to all individuals who are experiencing a wide range of behavioral health needs (Robinson & Reiter, 2016). Behavioral health services in the PCBH model frequently follow a stepped-care model in which BHCs provide lower initial levels of care (e.g., watchful waiting, psychoeducation) and transition to more complex, intensive interventions (e.g., recurring visits in primary care, referral to specialty mental health for individual/group therapy) as clinically indicated (Maragakis & Hatzigeorgiou, 2018). This highlights a radical shift from the traditional specialty mental health paradigms in which the focus is on providing moderate to high-intensity behavioral health interventions oriented towards the individual as the primary consumer.

The PCBH model of primary care integration has been related to a variety of multidimensional benefits. Hunter and colleagues (2018b) provide a review of the PCBH literature, specifically highlighting patient outcomes (i.e., satisfaction, daily functioning, symptoms) and PCBH implementation outcomes (i.e., acceptability, adoption, cost, fidelity, penetration). Despite this, current challenges within the PCBH model exist. Namely, there are recurrent challenges related to the funding of behavioral health consultants within this approach, contributing to sustainability challenges that limit the maintenance of behavioral health integration for primary care clinics (Hodgson & Reitz, 2013; Ma et al., 2022). Additionally, researchers have highlighted the shortage of BHCs being trained for this model of primary care integration (Hall et al., 2015). To address this challenge, leaders have taken steps to prepare the behavioral health workforce (e.g., mental health counselors, psychologists) for effective practice in the PCBH model through coursework (Lloyd-Hazlett et al., 2020) and site-based training (Dobmeyer et al., 2016), highlighting best-practices and outcomes. Despite these efforts, research surrounding clinical supervision that meets the professional development needs of novice clinicians for this model of primary care integration is lacking, contributing to a significant deficit in the available literature.

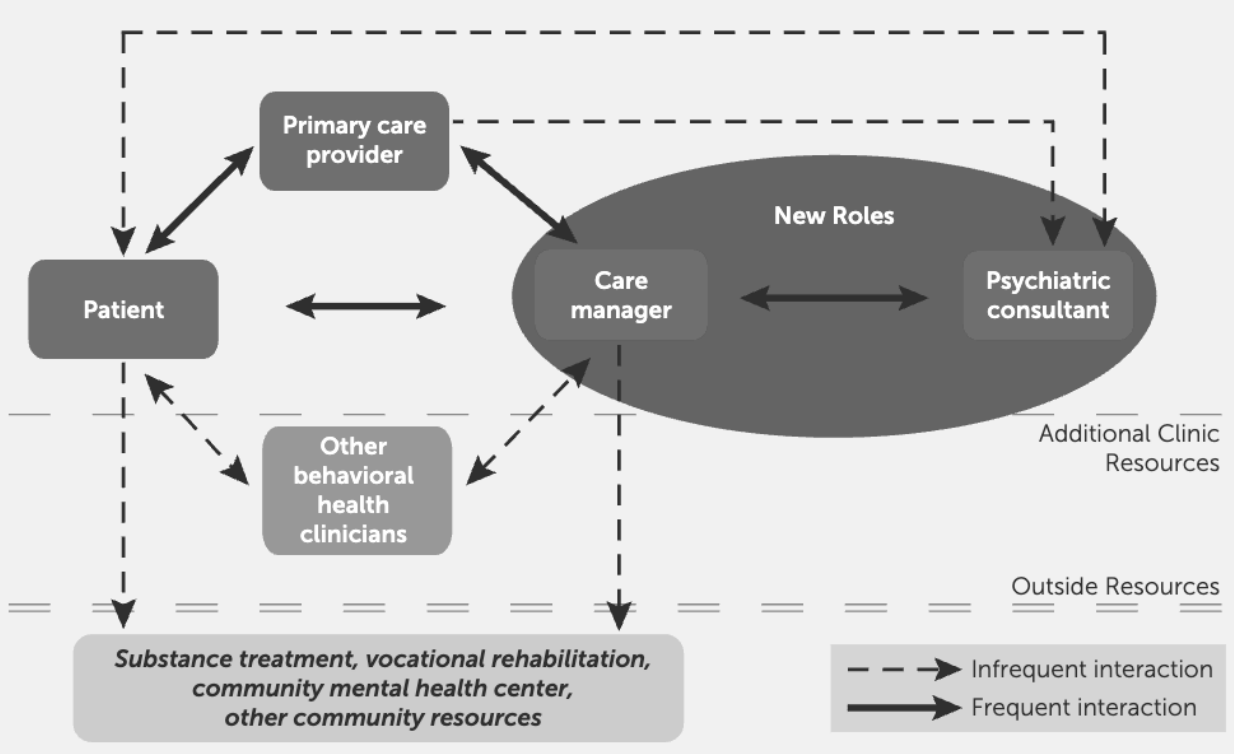
Collaborative Care Model

CoCM is a model of IBH emphasized by the integration of care management staff and psychiatric consultants into primary care settings, allowing for biopsychosocial monitoring and treatment of specific behavioral health concerns (Unützer et al., 2013). Within the CoCM approach to primary care, there are five vital components: 1) team-oriented, patient-centered care; 2) population-oriented care through patient tracking and registries; 3) measurement-oriented treatments focusing of clinical outcomes and patient goals; 4) evidence-based care

grounded in CoCM literature; and 5) accountability through reimbursement for the quality of care provided (American Psychiatric Association, n.d.). The purpose of this model of care is to provide comprehensive treatment from a care management perspective, targeting high-impact behavioral health concerns that may impact quality of life and medical concerns (Fiscella & McDaniel, 2018). This is one domain where the CoCM is distinct from other IBH models for primary care, as primary care teams provide targeted interventions for a specific population experiencing behavioral health concerns through collaboration, stepped care, and intentional observation of outcomes (Bao et al., 2016; Reist, et al., 2022). See Figure 2 for communication and collaboration patterns in the CoCM Model.

Figure 2

Communication and Collaboration in the CoCM from Raney (2015, p. 725)



An important distinction of the CoCM model as distinct from other models of IPC is the inclusion of a consulting psychiatrist as part of the care team (Center for Psychology and Health,

2022). Within this model, other providers in the care team (i.e., PCP, care manager) receive consultation and education on effective psychiatric medication management practices to enhance the provision of comprehensive care in the primary care clinic, particularly for patients who are not showing signs of clinical or functional improvement (Rayner, 2015; Whitebird et al., 2014). Within this role, consulting psychiatrists do not assume clinical responsibility for patients in the primary care clinic, instead deferring to the PCP for the prescription of psychiatric medication and ordering of additional testing as recommended during consultation (Rayner, 2015).

In addition to psychopharmacological support provided by a consulting psychiatrist, behavioral health support is provided by care managers. CoCM conceptualizes BHPs in this role, facilitating communication between members of the primary care team (i.e., PCP, psychiatric consultant, care manager, patient), assisting patients and families with navigating the healthcare system, and providing the patient with frequent contact, monitoring, and treatment of the targeted behavioral health concern (Belsher et al., 2018; Björkelund et al., 2018; Whitebird et al., 2014). Care managers have various responsibilities in this model, including assessment of care needs, creating and monitoring care plans, provide targeted interventions grounded in evidence-based practices (e.g., Motivational Interviewing, behavioral activation), coordinate care with providers within and outside of the primary care setting, communicate necessary information between providers and practices, coordinate the connection between the patient and necessary social and communal resources, and engage in quality improvement activities (Raney, 2015; Taylor et al., 2013). An important consideration is that care managers are not required to be licensed BHPs (e.g., mental health counselors, psychologists); this role can be fulfilled by nurses and bachelor's level social workers (Blount et al., 2017; Taylor et al., 2013).

The CoCM model has been extensively researched, with Gerrity (2016) conducting a review of over 90 studies spanning over 25,000 patients who exhibited clinical improvements after receiving primary care services through the CoCM. Within this review, it was found that the CoCM dimensions of trained care managers, intentional patient monitoring and follow-up by care managers, provider communication, and behavioral health interventions were most associated with patient improvement (Gerrity, 2016). CoCM has been found to be an effective model of care for depression across numerous high-impact CoCM initiatives, including the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT; Unützer et al., 2002), the Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND; Pietruszewski, 2010), and the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT; Bruce et al., 2004) projects. In addition to depression care, CoCM has been found to be an effective treatment approach for bipolar disorder (Bauer et al., 2006), anxiety disorders (Muntingh et al., 2016), and posttraumatic stress disorder (Fortney et al., 2015) in primary care.

As with the PCBH model, there are challenges associated with the CoCM approach to behavioral health integration in primary care. Implementation and cost-associated challenges have been identified as a significant barrier (Fiscella & McDaniel, 2018; Reist et al., 2022). Financially, reimbursement may be challenging for licensed BHPs practicing within a CoCM approach (Carlo et al., 2018; Center for Psychology and Health, 2017). Related, a concern highlighted by the Center for Psychology and Health (2017) is that BHPs may not be able to practice at the height of their license or degree due to their responsibilities as a care manager rather than an independent clinician. Finally, it has been identified that CoCM may be inadequate to address the complex concerns that primary care populations may present with for treatment (Fiscella & McDaniel, 2018). With these concerns in mind, paired with a unique model of

collaboration with PCPs and psychiatrists, new BHPs serving as care managers may have specialized training needs for their effective role fulfillment in CoCM primary care settings. While it has been identified that appropriate supervision is vital for the provision of effective services from a CoCM perspective (Unützer et al., 2013), there is a lack of understanding of what new clinicians in these primary care settings need from their SORs.

A Blended Approach – PCBH and CoCM

When conceptualizing behavioral health integration in primary care, PCBH and CoCM models provide services from different paradigms, target populations, and responsibilities of BHPs. While uniquely effective in practice, researchers have highlighted challenges in that may contribute to significant barriers providing comprehensive behavioral health services to individuals in primary care settings (Westfall, 2022). It is suggested that a blended approach to behavioral health integration in primary care, combining the complimentary nature of both PCBH and CoCM approaches, may be the most appropriate to attend to the wide range of needs identified in patients receiving primary care (Center for Psychology and Health, 2019; Hunter & Goodie, 2010; Raney et al., 2017).

For patients presenting with subclinical or episodic behavioral health needs impacting quality of life or medical care, the PCBH approach may be ideal to provide them with targeted, evidence-based interventions; conversely, for patients presenting with identified mental health diagnoses, a CoCM approach can be utilized for ongoing psychiatric monitoring and check-ins for longitudinal care that attends to biopsychosocial concerns in primary care settings (Center for Psychology and Health, 2019). Unützer (2016) comments that these approaches are highly complementary, potentially providing patients and providers with the most effective processes for addressing all behavioral health needs in a primary care setting. Therefore, it becomes

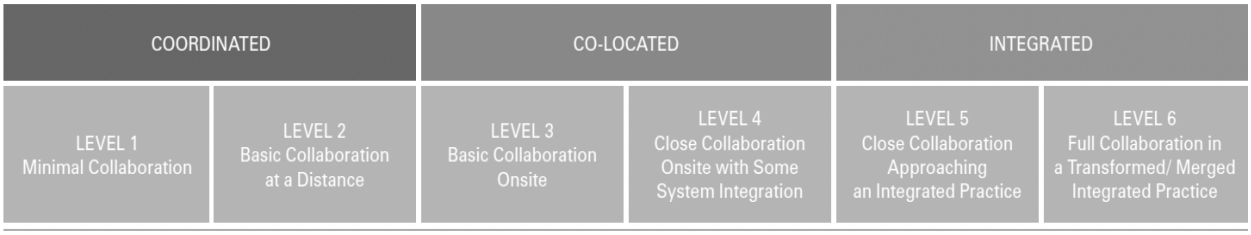
important that BHPs are adequately trained and supervised to practice from CoCM, PCBH, and blended CoCM-PCBH approaches.

Levels of Care Integration in Primary Care

The Center for Integrated Health Solutions associated with the Substance Abuse and Mental Health Services Agency and Health Resources and Services Administration (SAMHSA-HRSA) created an implementation framework for categorizing various levels of integrated care (see Figure 3; Heath et al., 2013). This implementation framework provides stakeholders in IPC with a continuum of collaboration that ranges from coordinated to co-located to integrated care (Getch & Lute, 2019). These levels of primary care and behavioral health integration were first conceptualized by Doherty and colleagues (1996), spanning five levels of integration to guide initial efforts to systematically understand and implement behavioral health integration in primary care.

Figure 3

Levels of Care and Collaboration Outlined by Health and Colleagues (2013)



Coordinated Care

Coordinated care is conceptualized as the lowest categorization of behavioral health integration, including minimal to nonexistent collaboration between providers at separate practices or basic collaboration between providers across different practices (Heath et al., 2013). The crucial component of coordinated levels of care include communication that occurs across separate agencies (Brown et al., 2021; Getch & Lute, 2019). Frequently, healthcare providers

working from traditional biomedical, and specialty mental health models engage in coordinated care as they attempt to ensure that comprehensive needs are met, often through referrals and/or basic clinical updates as warranted (Brown et al., 2021).

The coordinated care approach has been understood as an effective was to improve outcomes, experiences, and exposure to the wide range of available healthcare services while simultaneously limiting healthcare expenditures (Poku et al., 2019). Additionally, these levels of care allow for practices to maintain autonomy and internal systems (Heath et al., 2013). However, this level of care may be associated with various challenges, including patient barriers in accessing clinical services due to fragmentation of different healthcare services (Stange, 2009), geolocation (Dew et al., 2013) and/or discrimination (Yearby et al., 2018). Due to the alignment of coordinated care with traditional models of specialty mental health care, many BHPs may be receiving necessary training to practice in this level, providing collaborative care with PCPs as needed.

Co-Located Care

Co-located care is conceptualized as a moderate categorization of behavioral health integration, including basic collaboration of providers within the same site or close provider collaboration with minimal systemic integration (Heath et al., 2013). The crucial component of co-located levels of care includes interdisciplinary proximity and sharing of resources within the same building or practice (Brown et al., 2021; Getch & Lute, 2019). BHP co-location with PCPs is increasing (Richman et al., 2020), highlighting the evolution of the healthcare system to increase the access of behavioral health services in primary care. Within these co-located levels of care, each provider maintains independent responsibility of patient within their specialty (e.g., primary care, behavioral health), each making independent decisions that may be influenced by

information available through systems (i.e., electronic medical record) that have begun the process of integration (Brown et al., 2021).

Co-location has been found to be associated with more frequent interprofessional collaboration, more successful referrals to behavioral health services, and greater understanding of interdisciplinary roles and skills (Bonciani et al., 2018; Brown et al., 2021; Heath et al., 2013). However, challenges associated with co-located levels of care include interdisciplinary provider tension, limited provider buy-in to co-located models, minimal levels of interprofessional collaboration despite greater communication, and poorer patient experiences when comprehensive health services are provided in a setting with poor structure (Bonciani et al., 2018; Brown et al., 2021; Heath et al., 2013; Pujalte et al., 2020). Due to shifts in expectations for BHPs in co-located settings, it becomes important to effectively train and supervise new clinicians for nuanced work in increasingly collaborative healthcare settings.

Fully Integrated Care

Fully integrated care is conceptualized as the highest categorization of behavioral health integration in primary care, including close collaboration approaching an integrated practice or full collaboration in a transformed/merged integrated practice (Heath et al., 2013). This categorization of integration is emphasized by organizational sharing of policies, practices, and systems to enhance interprofessional collaboration as a cohesive team towards biopsychosocial patient care (Brown et al., 2021; Getch & Lute, 2019; Peek & Council, 2013). Full integration is often best implemented when providers have a shared vision and community of care, a shared medium for communication and information sharing, shared alignment towards goals and strategies for maintaining integration (e.g., reimbursement, actionable steps towards meeting goals), and shared accountability towards the provision of quality care (Poku et al., 2019).

Advantages of a fully integrated approach include enhanced provider and patient satisfaction, systemic barriers complicating referral coordination being systemically addressed within the organization, increased attention to holistic health concerns, and improvements in patient treatment adherence (Heath et al., 2013; Reiss-Brennan et al., 2016; Vogel et al., 2012). Disadvantages of this approach include sustainability and reimbursement challenges, interdisciplinary tension adapting to new organizational practices related to interprofessional collaboration, and the significant amount of organizational and interprofessional resources needed to establish fully integrated care (Heath et al., 2013; Li et al., 2022; Prom et al., 2021; Reiss-Brennan et al., 2016). Due to a radical shift in organizational practices and expectations with fully integrated levels of care, BHPs and educators may need to invest significant time, energy, and resources to effectively train new clinicians (Serrano et al., 2018). This includes meeting the unique needs of novice BHPs in primary care clinics in supervision.

Outcomes of Integrated Behavioral Health in Primary Care

Outcomes in IBH are often multifaceted, seeking not just to improve patient care and satisfaction, but to simultaneously reduce total expenditures and enhance the wellness of individual providers, known together as the Quadruple Aim of healthcare (Bodenheimer & Sinsky, 2014). This deviates from outcomes in specialty mental health, where the focus on outcomes is primarily on the individual being served. Within the IPC approach, outcomes are focused on healthcare that meets the need of the wide range of stakeholders in IBH, including patients, interdisciplinary providers, organizations, and the greater healthcare system. Quality improvement has been identified as a vital component of IBH in primary care (O'Donohue, 2018; Peek & Council, 2013). This encourages clinicians, leaders, and researchers to continuously evaluate the effectiveness and outcomes of biopsychosocial primary care services,

adapting the implementation of IBH services to better meet the goals of the Quadruple Aim. It becomes important for researchers to understand the various benefits and outcomes associated with behavioral health integration in primary care.

Quadruple Aim

The integration of behavioral health in primary care places emphasis on meeting the Quadruple Aim of healthcare, in which care seeks to enhance population health outcomes, enhance patient satisfaction, reduce total healthcare expenditures, and enhance provider well-being and satisfaction (Center for Psychology and Health, 2022; Bodenheimer & Sinsky, 2014). As new and experienced healthcare professionals conceptualize the feasibility, development, implementation, and evaluation of behavioral health integration in primary care, it becomes important to recognize the effectiveness of IPC through the Quadruple Aim paradigm.

Enhancing Clinical Outcomes. A connecting factor across the wide range of behavioral health professions that may serve as BHPs in IPC settings is the ethical principle of beneficence. While language is different between professions' ethical codes, the aim to do the most good while minimizing opportunities for harm is consistent (American Association for Marriage and Family Therapy [AAMFT], 2015; American Counseling Association [ACA], 2014; American Psychological Association [APA], 2016; National Association of Social Workers [NASW], 2021). This value of beneficence is also shared in medical professions, such as the American Medical Association and the American Nurses Association (Byrd & Winkelstein 2014). Therefore, it is apparent that one of the outcomes of behavioral health integration in primary care is related to enhancing the lives of patients served through improved clinical outcomes.

The role of clinician, spanning targeted assessment and intervention, has been identified as an important component of being a BHP in the primary care context (Glueck, 2015). Within

the primary care context, comprehensiveness is an important consideration for healthcare providers as they seek to enhance the biopsychosocial health and wellness of individuals who receive care (Jimenez et al., 2021). IBH in primary care settings has been related to a 24-times increase in holistic functioning across a 12-month integrated treatment period, a significant difference when compared treatment as usual (Schmit et al., 2018). This highlights a significant benefit of IPC initiatives, as they may improve the overall functioning of those who receive behavioral health in primary care through coordinated efforts to address medical and behavioral health concerns.

When behavioral healthcare provided by BHPs embedded in primary care is available, researchers have identified significant improvements in symptoms related to both behavioral health and medical conditions. Within primary care, depression and anxiety are frequently the most common behavioral health diagnoses PCPs and BHPs will encounter and treat (Erazo & Hazlett-Stevens, 2018; Funderburk et al., 2011; Mikeal & Gillaspy, 2018). Therefore, the effectiveness of behavioral health interventions in primary care has significant implications for patients' clinical outcomes. Behavioral health services in primary care have repeatedly been found to be associated with significant clinical improvements in depression (Balasubramanian et al., 2017; Chen et al., 2021; Duncan et al., 2021; Hunter et al., 2018b; Ross et al., 2019; Powers et al., 2020; Unützer et al., 2002) and anxiety (Hunter et al., 2018b; Ross et al., 2019; Ulupinar & Zalaquett, 2022).

In addition to anxiety and depression, the integration of behavioral health in primary care has been found to be related to significant reductions in symptoms of posttraumatic stress disorder (PTSD; Chen et al., 2021; Cigrang et al., 2015). This has various implications for behavioral health care for trauma-related concerns in primary care clinics. Adverse childhood

experiences (ACEs) in primary care populations are common and have been found to be related to a variety of adverse health behaviors and lifestyle factors, chronic medical conditions, and behavioral health diagnoses (Felitti et al., 1998; Hughes et al., 2017; Kalmakis et al., 2018; Koball et al., 2019), therefore effective treatment of lifetime traumatic experiences becomes an important target for BHPs in IPC settings.

Recommendations for the treatment of other behavioral health concerns in primary care settings have been outlined, including targeted treatment and stepped-care interventions for borderline personality disorder (Arble & Krasean, 2018), generalized stress (Vechiu & O'Donohue, 2018), serious mental illness (Maragakis & Vriesman, 2018), obsessive compulsive disorder (Sewell et al., 2018), excoriation and trichotillomania (Lee et al., 2018), and others (e.g., oppositional defiant disorder; see Maragakis & O'Donohue, 2018). This highlights the potential for enhancing clinical outcomes for a wide range of clinical and sub-clinical behavioral health concerns in primary care settings through BHPs using evidence-based practices in collaborative treatment settings.

Integration of BHPs in primary care settings have also been found to be effective in clinical outcomes related to medical concerns that may contribute to and/or exacerbate chronic illnesses. BHP integration in primary care has been related to significant decreases in low-density lipoprotein values, hemoglobin A1c values, and body mass index values (Ross et al., 2019). Additionally, recommendations for behavioral health treatment in primary care have been created for chronic medical conditions such as chronic pain (Darnall, 2019; Duckworth et al., 2018; Rickert et al., 2016), cancer (Burg & Adorno, 2016; Dornelas, 2017; Sherman et al., 2018), diabetes (Bauman et al., 2018; Butkiewicz et al., 2016), cardiovascular diseases (Burg, 2018; Goetz et al., 2016), and obesity (Lawrence & Abel, 2016; Lindeman & Maragakis, 2018).

Related, primary care and behavioral health integration have been found to be related to increased coping skill utilization, appointment attendance, recommended specialist follow-up, use of relapse prevention plans, and medication adherence (Prom et al., 2021; Robinson et al., 2020). These findings indicate the far-reaching implications of behavioral health integration into primary care, as BHPs may have the opportunity to significantly enhance clinical outcomes in patients with various behavioral health, medical, and comorbid medical and behavioral health concerns.

Enhancing Patient Satisfaction and Experience. Patient satisfaction is a targeted outcome within the Quadruple Aim and seeks to enhance the overall experience so that healthcare is "patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality" (Hunter, 2013, p. 191). Researchers have identified that higher patient satisfaction and experience are related to higher clinical effectiveness and patient safety (Doyle et al., 2013) and lower patient satisfaction being related to poorer mental health and increased emergency healthcare utilization (Chen et al., 2019), indicating the importance of this dimension in the Quadruple Aim. Patients have identified various concerns related to siloed primary care and behavioral health, including PCP stigma and inexperience towards behavioral health concerns, difficulty accessing and affording behavioral health services, unfamiliarity with behavioral health concerns and options for treatment, conflict with members of the healthcare team, and unresolved behavioral health concerns within the primary care context (Dew et al., 2013; Parker et al., 2020; Robinson et al., 2012; Valeras et al., 2019). With these challenges and concerns in mind, enhancing patient satisfaction with the care they have accessible and receive becomes vital.

Patients in primary care settings with an embedded BHP have consistently reported overall satisfaction with the care they received (Balasubramanian et al., 2017; Ede et al., 2015; Hunter et al., 2018b; Ogbeide et al., 2018; Robinson et al., 2020; Ross et al., 2019; Rowan et al., 2021). Upon further examination, IBH in primary care settings is related to various dimensions of enhanced patient satisfaction and experience with care. Patients in IPC settings indicated high satisfaction related to equitable treatment, skill growth for managing behavioral health concerns, and location of behavioral health services within the primary care context (Balasubramanian et al., 2017; Ede et al., 2015). There have been mixed results related to whether patient satisfaction and experience receiving behavioral health services in the IPC context have contributed to increased willingness to follow-up with specialty mental health, with certain populations (i.e., military) being more open than other populations (i.e., rural residents); this may be attributable to stigma of or access to behavioral health (Ogbeide et al., 2018).

Stigma from both patient and provider surrounding behavioral health has been found to be mediated within IPC settings (Rowan et al., 2021), potentially contributing to greater accessibility and acceptability of behavioral health for historically underserved populations (O'Loughlin et al., 2019; Ogbeide et al., 2016; Scafe et al., 2021). Reducing patient and provider stigma towards behavioral health is an important component of BHP integration in primary care, contributing to greater satisfaction with and acceptability of behavioral health care. The IPC context for underserved communities has been identified as an effective way to ensure underserved communities have access to behavioral health that is perceived as helpful, effective, and accessible (Miller-Matero et al., 2019; Zhou & Kole, 2022). Due to known disparities in healthcare for historically underserved and marginalized communities (Yearby, 2018), paired with the effect of stigma on attitudes of seeking specialty behavioral health (Fripp & Carlson,

2017), ensuring high levels of patient satisfaction and experience with care may reduce disparities and contribute meaningfully to patients' health.

Reducing Healthcare Expenditure. In 2021, U.S. healthcare expenditure was $4.3 trillion, amounting to almost $13,000 per person or 18.3% of the gross domestic product (GDP; Centers for Medicare & Medicaid Services [CMS], 2022). When compared to similar countries globally, the U.S. was found to spend more of its GDP on healthcare despite less access, efficiency, equity, and outcomes of healthcare services (Schneider et al., 2021). This highlights the need for healthcare services to reduce patient and payer spending on healthcare services.

Researchers have highlighted higher healthcare expenditures through utilization of high-cost healthcare services (e.g., emergency department, prolonged hospitalization) for individuals with behavioral health concerns such as serious mental illness or suicidality (O'Reilly et al., 2022) and comorbid medical and behavioral health concerns (Lee et al., 2015). Specifically, ACEs have been related to increased emergency care utilization, more scheduled and missed appointments at primary and specialty medical care, decreased medical care utilization, and a higher likelihood of chronic medical concerns (Felitti et al., 1998; Hargreaves et al., 2019; Koball et al., 2019). Additionally, the fragmentation of healthcare services has been found to be related to higher healthcare costs for individuals with chronic illness (Joo, 2023). These indicate the need for comprehensive primary care that can provide early intervention and treatment for biopsychosocial health concerns to minimize healthcare expenditures.

The integration of BHPs in primary care contexts has been found to lower healthcare expenditure for individual patients and organizations. Researchers have found that embedded behavioral health services in an existing primary care clinic were related to a 10.8% or $860.16 cost savings per year per patient (Ross et al., 2019). Additionally, probability of hospitalization

decreased by 18%, amounting to approximately $1000 worth of saving per patient per year, while the average length of hospitalization decreased by 32% or three days, amounting to a savings of $1324 per patient hospitalization (Wells et al., 2018). Specifically for rural communities, the provision of behavioral health in primary care in a large healthcare organization has been found to be related to large reductions in cost for emergency, laboratory, outpatient, and primary care services (Peterson et al., 2017). Finally, team-based integrated care has been related to lower rates of healthcare utilization related to emergency departments, outpatient care, and hospital admission, as well as reduced overall costs for patients with behavioral health and medical concerns (Reiss-Brennan et al., 2016).

These studies indicate the benefits of the provision of behavioral health services in the primary care context within this dimension of the Quadruple Aim. Additional efforts to address cost-savings in IPC may include proper diagnosis, improving health behaviors that contribute to higher health expenditure (e.g., lifestyle factors, treatment adherence), providing low-intensity services to prevent high-cost, high-intensity healthcare utilization when unnecessary, and specifically targeting individuals who are more likely to engage in high healthcare utilization behaviors (O'Donohue, 2018).

Enhancing Provider Satisfaction and Wellness. Initially, the Quadruple Aim was conceptualized as the Triple Aim, adding the dimension of provider satisfaction and wellness in response to healthcare provider burnout (Bodenheimer & Sinsky, 2014). There are expected workforce shortages for medical (American Association of Colleges of Nurses, 2022; American Association of Medical Colleges, 2021) and behavioral health (Covino, 2019) providers in the coming years, indicating a pressing need to enhance healthcare provider wellness and satisfaction with their work.

Physicians seem to be at higher risk for burnout than the general population, especially those who work in specializations most associated with primary care (i.e., internal medicine, family medicine), with over one-third of all physicians experiencing burnout (de Hert, 2020). Additionally, physicians may experience more frustration and behavioral health concerns in early stages of their career, when working longer hours, and when providing care to a high number of patients with behavioral health concerns (Krebs et al., 2006; Patel et al., 2018). This may have been exacerbated by the COVID-19 pandemic, with symptoms of burnout being higher among physicians during 2021 when compared to early stages of the pandemic and pre-pandemic years (Shanafelt et al., 2022). Burnout in physicians may then contribute to serious consequences among other dimensions of the Quadruple Aim, including lower patient satisfaction, poorer clinical care, and increased costs for patients and other healthcare organizations (de Hert, 2020; Patel, 2018). Additionally, BHPs have been found to experience various dimensions of burnout, indicating high levels of exhaustion, overextension, depletion, and disconnection (O'Connor et al., 2018). Common workplace factors contributing to burnout in physicians and PCPs include high workplace demands (e.g., high caseloads), lack of role clarity, and an absence of support (de Hert, 2020; O'Connor et al., 2018), concerns that may be present for many providers in IPC settings.

Within IPC settings, PCPs have consistently indicated high satisfaction with BHP integration, citing improvements in patients' clinical outcomes and providers' professional quality of life by lowering stress and increasing professional support (Ede et al., 2015; Miller-Matero et al., 2016; Powers et al., 2020; Ross et al., 2019). Additionally, higher levels of integration in primary care have been found to be associated with lower levels of burnout (Zubatsky et al., 2018). PCPs have indicated that in the presence of financial losses within the

clinic, they would maintain behavioral health integration due to the widespread benefits to patients, providers, and organizations (Malâtre-Lansac et al., 2020). BHPs and care coordinators have also been found to be positively influenced by behavioral health integration in primary care, with these professionals indicating high satisfaction with their work in IPC settings and lower levels of burnout in contrast to BHPs in other settings (Au et al., 2018; Berkel et al., 2019; Zubatsky et al., 2020). Within IPC settings, significant strides are being made towards ensuring provider wellness and satisfaction, meeting this final dimension of the Quadruple Aim.

The Quadruple Aim as a Cohesive Goal

The Quadruple Aim can be conceptualized as an overarching framework for continuous quality improvement efforts to ensure multidimensional benefits of healthcare services in the U.S. Additionally, it is highly likely that each dimension of the Quadruple Aim is intricately interrelated with the other three dimensions. For example, it is likely that patient satisfaction contributes to more improvements in clinical outcomes, reduced healthcare expenditures, and enhanced provider satisfaction with the services being provided, and vice versa for each component. For novice clinicians, it becomes important that they receive adequate training on the dimensions of the Quadruple Aim so that they can provide behavioral health services that seek to enhance each dimension, including prevention of BHP burnout in these settings. To best navigate the nuances of these settings, clinical supervision that meets the needs of novice BHPs becomes imperative to ensure outcomes in IPC are met.

Challenges of Behavioral Health Providers in Integrated Primary Care

While the provision of IBH services in primary care are related to considerable gains in all dimensions of the Quadruple Aim, there remain significant challenges for BHPs as the integrate into the primary care context. For many BHPs, there may be challenges initially

integrating into the primary care context, particularly when responding to the fast-paced, population-oriented focus of the primary care setting (Cox et al., 2014). When integrating into these spaces, BHPs often need to change their style of practice to respond to the culture and systems within primary care (Glueck, 2015), which may include frequent interprofessional collaboration and communication about patient care (Li et al., 2022; Prom et al., 2021), frequent interruptions from primary care staff (Cox et al., 2014; Dice et al., 2022), and navigation of systemic barriers to behavioral health care in traditional medical settings (Li et al., 2022). Professional practice in IPC settings is also prone to unique ethical challenges that may require BHPs to look past their own profession's ethical codes during the ethical decision-making process (Kanzler et al., 2013; Runyan et al., 2018).

Another important dimension of challenges experienced by BHPs in IPC settings are related to the skills, knowledge, and conceptualizations of behavioral health needed for effective clinical practice. BHPs in IPC settings have identified challenges with understanding their roles, responsibilities, and professional identity within the primary care context (Berkel et al., 2019; Cox et al., 2014; Li et al., 2022). Oftentimes, BHPs in these settings fulfill various roles and rely on skills outside of the traditional clinician role primarily expected in specialty mental health models (e.g., referral coordinator, educator; Glueck, 2015). Many novice BHPs, though, may struggle to oscillate between these various roles depending on the situation, contributing to a sense of being overwhelmed and unclear on their roles and responsibilities.

A final significant challenge repeatedly identified by BHPs in primary care settings is the perception that their training to date has been unsuccessful in preparing them for practice in IBH settings (Cox et al., 2014; Dice et al., 2022; Li et al., 2022; Prom et al., 2021). Currently, there are established competencies for BHPs in primary care, which include but are not limited to:

interprofessional communication and collaboration skills, advanced conceptualizations of biopsychosocial presentations, understanding of psychopharmacology and other medications, evidence-based targeted interventions, health informatics, and awareness of teaching strategies for interdisciplinary settings (Hoge et al., 2014; McDaniel et al., 2014; Sockalingam et al., 2020). This highlights the need for intentional efforts to incorporate IBH education into behavioral health training initiative, spanning graduate education and clinical supervision.

Clinical Training for Integrated Primary Care

Researchers have highlighted the shortage of BHPs trained specifically to practice in IPC settings (Blount & Miller, 2009; Ma et al., 2022), and the need to retrain BHPs for these settings (Serrano et al., 2018) due to the fast-paced, population-health orientation in IPC (Dobmeyer et al., 2016). This highlights the need for intentional efforts to train the next generation of BHPs for interprofessional, team-based healthcare. McDaniel and colleagues (2014) have identified that many educational programs for BHPs may not be providing students with the necessary training to provide behavioral health services in primary care contexts. Many BHPs new to IBH settings learn the skills and knowledge needed through on-the-job experiences (Asempapa, 2019; Blount et al., 2017; Horevitz & Manoleas, 2013), potentially contributing to the provision of services that do not adequately meet components of the Quadruple Aim. When provided with training, BHPs have been found to have enhanced self-efficacy, professional identity, knowledge and competence of IPC practices, and understanding of interprofessional roles (Fields et al., 2022). This indicates a need for effective training initiatives that focus on IPC for BHPs. As leaders, educators, and SORs conceptualize the supervisory needs of new BHPs in IPC, understanding the current state of behavioral health training becomes important.

Graduate Education for Integrated Primary Care

Graduate education is a requirement for licensure as a BHP regardless of professional setting, spanning a master's and/or doctoral degree in clinical mental health counseling, clinical psychology, clinical social work, and/or marriage and family therapy. The overarching purpose of graduate training programs for BHPs is to promote professional development and provide training relevant to the competencies, skills, and knowledge required for effective practice through didactic and supervised clinical learning experiences (e.g., APA, 2013; Council for the Accreditation of Counseling and Related Programs [CACREP], 2016). This education often includes both didactic and experiential learning opportunities through formal coursework and supervised practicum/internship. Researchers have found that because of graduate education, BHPs-in-training experience significant growths in self-efficacy from new student orientation to clinical practicum orientation, and from clinical practicum orientation to final internship meetings (Mullen et al., 2015). Given the importance of behavioral health education for BHPs, IPC training for students becomes an important factor to consider.

Currently, there may not be enough specialized training through coursework, practicum, internships, and/or fellowships focusing on IPC to meet the needs of an evolving workforce (Mullin & Funderburk, 2013). A common experience reported by organizations is the challenge of recruiting and hiring clinicians with the necessary skills and knowledge needed for effective practice in IPC settings (Hall et al., 2015). Various researchers have highlighted the need for intentional, specialized training for BHPs-in-training during their graduate education (Dice et al., 2022; Glueck, 2015; Hall et al., 2015; Horevitz & Manoleas, 2013; Li et al., 2022; Schmoyer et al., 2023; Zubatsky et al., 2016). These calls for IBH education in BHP training programs, paired with a current shortage of BHPs trained in IPC (Blount & Miller, 2009; Hall et al., 2015) and

known benefits of IPC through the Quadruple Aim, highlight an imperative for behavioral health educators, leaders, and SORs to prioritize and enhance the IPC preparation of BHPs.

Graduate Coursework and Training

Training initiatives focusing on IPC in graduate programs have been developed in various BHP training programs, including mental health counseling (Agaskar et al., 2021; Lenz & Watson, 2022; Lloyd-Hazlett et al., 2020), psychology (Berkel et al., 2019; Boland et al., 2019), and social work (DeBonis et al., 2015; Putney et al., 2017). The focus of these initiatives has been to train BHPs on the intricacies of IPC work, encapsulating topics such as IBH models (e.g., PCBH), health behavior change, common behavioral health conditions presenting in primary care settings, common medical conditions presenting in primary care settings, evidence-based practices for behavioral health and chronic illness management (e.g., Cognitive-Behavior Therapy, Solution Focused Brief Therapy, Motivational Interviewing), health disparities, medication in IPC, ethical and cross-cultural considerations for IPC, and interprofessional collaboration (Agaskar et al., 2021; Boland et al., 2019; Cox et al., 2014; DeBonis et al., 2015; Lloyd-Hazlett et al., 2020; Ogbeide et al., 2022). These topics align with competencies identified to be pertinent for BHPs in IPC settings (Hoge et al., 2014; McDaniel et al., 2014; Sockalingam et al., 2021), indicating the potential for this coursework to meaningfully contribute to BHPs preparedness for practice in IPC settings.

Within specialized coursework, various benefits have been identified for behavioral health students. Significant increases in multicultural competence, interprofessional collaboration competencies, attitudes towards evidence-based practices, and suicide intervention response have been identified due to IPC coursework for counseling students (Agaskar et al., 2021; Lenz & Watson, 2022). Additionally, a study exploring the impact of an IPC course in social work

education found that students indicated satisfaction with the course, gained necessary knowledge and skills for IBH work, improved their confidence in applying knowledge and skills to IBH practice, and enhanced their perception of the roles of social workers in primary care (DeBonis et al., 2015). While these studies show preliminary evidence of the effectiveness of IPC coursework during graduate education, these practices are not widespread and likely contribute to an underdeveloped IBH workforce (Hall et al., 2015). For novice BHPs in IPC settings, a lack of formal IBH training in graduate education may contribute to challenges and needs that must be addressed during supervised clinical practice during graduate education or upon graduation.

Interprofessional Education. Interprofessional education (IPE) "occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, 2010, p. 13). Various professions who may work in IPC settings have encouraged increased accessibility of IPE opportunities during coursework and internship opportunities, including behavioral health (Cubic et al., 2012; Johnson & Freeman, 2014; Jones & Phillips, 2016), medicine (Zechariah et al., 2019), and support staff (Cranford & Bates, 2015; Schmoyer & Carlisle, 2023). IPE is oriented towards enhancing competencies in interprofessional collaboration, spanning interprofessional values and ethics, roles and responsibilities, communication, and teamwork as a cohesive team (Interprofessional Education Collaborative [IPEC], 2016).

For BHPs-in-training, IPE initiatives have been related to a variety of outcomes, including enhanced perceptions of interprofessional teams, learning, and practice (Johnson et al., 2015; Lloyd-Hazlett et al., 2022; Zucchero, 2017). Additionally, IPE has been found to be related to significant growths in behavioral health students' team-based skills, interprofessional socialization and valuing, cultural and linguistic competencies, and professional development

(La Guardia et al., 2022; Zanskas et al., 2022). These findings indicate that IPE is related to a variety of benefits that contribute to an enhancement of trainees' professional identity, interprofessional skills, and appreciation for the nuances of interprofessional collaboration. Due to the inherent collaborative nature of IPC (Peek & Council, 2013), the provision of IPE may set novice BHPs up for success as they integrate into settings in which interprofessional collaboration is the norm.

Supervised Practicum and Internship in Primary Care

A vital component of graduate behavioral health education is supervised clinical experience gained through practicum and internship. Researchers have found practicum and internship to be a critical experience for graduate students of behavioral health professions (Furr & Carroll, 2011), contributing to significant transformations within personal and professional domains (DeCino et al., 2020), growth in necessary skills and knowledge for competent practice (Rodriguez-Menendez et al., 2017), and movement from lower to more advanced developmental stages (Kaiser et al., 2012). For counseling students, higher levels of internship coursework, when paired with concurrent coursework and instruction related to counseling, are related to increased counseling self-efficacy (Tang et al., 2004). Related, Mullen and colleagues (2015) found a significant increase in counseling self-efficacy among counseling students from the start of practicum to the end of internship. Due to the requirement for supervision during internship experiences for various behavioral health professions (Bernard & Goodyear, 2019), the effect of supervision in these learning experiences cannot be overlooked. These findings highlight the importance of supervised clinical experience during graduate education, highlighting the need for accessible IPC internship opportunities for BHPs-in-training.

For many BHPs in primary care settings, most of their training likely stems from their internship experiences (Mullin & Funderburk, 2013). Regarding IPC internship opportunities, researchers have found that IPC internships are available in only 55% of all doctoral psychology training programs (Cubic et al., 2011). Additionally, researchers found discrepancies between counseling students' interest in internship placement at integrated care sites (92.2%) and actual placement (33%; Asempapa, 2019). Dobmeyer (2018) has identified that there is still a gap in supervised training in graduate education despite some growth in this area, with the potentially instrumental role of increasing the availability of these training opportunities.

Parallel to coursework, practicum and internship experience is related to significant benefits for BHPs-in-training. Novice BHPs identified graduate level practicum experiences in IPC settings as influential in their professional development as BHPs in these settings (Berkel et al., 2019; Dice et al., 2022). Additionally, BHPs in their practicum experience indicated that practicum and internship training was related increases in knowledge, skills, and comfort with IPC practice (Dice et al., 2022; Possis et al., 2016). This may be related to training strategies provided to internship-level BHPs in IPC settings, including a focus on teaching skills and competencies for behavioral health providers in these settings (i.e., orientation to primary care context and culture, improving skills for interprofessional teamwork, developing professional identity, administrative tasks), providing extensive onboarding, shadowing opportunities, structured learning, interprofessional education, and flexible and interdisciplinary supervision opportunities (Dobmeyer et al., 2003; Ma et al., 2022). Within the IPC internship literature, consistent, IPC focused supervision for BHPs is a constant (Cox et al., 2014; Dice et al., 2022; Dobmeyer et al., 2003; Ma et al., 2022; Possis et al., 2016). While highlighting the necessity of

clinical supervision for novice BHPs in their IPC internship experiences, it also becomes critical for clinical supervision in these training efforts to meet the needs of developing clinicians.

Clinical Supervision and Integrated Primary Care

In IPC settings, there are a variety of stakeholders that can influence the delivery and quality of care, including medical providers (e.g., physicians, nurse practitioners), medical support staff (e.g., nurses, medical assistants), BHPs (i.e., clinical mental health counselors, clinical psychologists, clinical social workers, marriage and family therapists), ancillary care professionals (i.e., physical therapists, occupational therapists), care enhancers (e.g., care coordinators, health navigators), nonclinical staff (e.g., office staff, environmental services), and healthcare administration and leadership (Blount et al., 2017; Robinson & Reiter, 2016). In these systems, clinical SORs have an important responsibility of ensuring quality services, gatekeeping their respective professions, and training future professionals. Therefore, it is important to understand the purpose and impact of supervision for novice BHPs, as well as the nuances of supervision within the IPC context.

Clinical Supervision

Clinical supervision is conceptualized as a professional relationship and intervention in which a more experienced member of a profession works with a less experienced member of a profession to enhance their personal and professional growth as a member of said profession (Bernard & Goodyear, 2019; Corey et al., 2021). It has been identified as the "signature pedagogy" of behavioral health training by Bernard and Goodyear (2019, p. 2), being a vital component for graduate training across behavioral health disciplines (Tugendrajch et al., 2021). Since the 1980s, clinical supervision has been conceptualized as a distinct specialization within the context of behavioral health professions (Bernard & Goodyear, 2019; Borders, 2014; Borders

et al., 2014; Dye & Borders, 1990). Best practices in supervision have been identified by researchers, providing additional structure for interdisciplinary SORs to enhance their practice (Borders, 2014; Borders et al., 2011; Borders et al., 2014). This highlights the importance of supervision within the behavioral health field, separating it as a distinct yet complimentary specialization when compared to clinical, research, and educative components of behavioral health professions.

Within clinical supervision, SORs frequently use theoretical models to assist in conceptualizing the supervisory relationship, interventions, and function (Borders & Brown, 2022). There are three broad conceptualizations of supervision models that may guide SORs' practices in supervision: 1) developmental models; 2) psychotherapy models; and 3) integrative models (Corey et al., 2021). These models may allow for SORs to conceptualize the ideal role they may integrate into their approach for each supervisory event (e.g., Discrimination Model; Bernard, 1979), the developmental level of a SEE and the most appropriate interventions for continued growth (e.g., Integrative Developmental Model; Stoltenberg & McNeill, 2010), and/or ways to enhance the SEE's practice within a specific theoretical approach (e.g., Cognitive-Behavioral Therapy). While it is past the scope of this study to explore each supervision model and its applicability to supervision IPC settings, it is important to acknowledge the ways in which supervision may be provided within the context of SORs meeting novice BHPs' needs.

Purpose of Clinical Supervision

The primary goals of clinical supervision in behavioral health are multidimensional, spanning personal and professional development of a novice BHP, protecting the wellbeing of individuals served by novice BHPs, and gatekeeping the profession to ensure the integrity of the profession and training site (e.g., university, agency) and protect society from BHPs who do not

meet professional standards of care (Bernard & Goodyear, 2019; Borders et al., 2014). When further dissecting the functions of supervision, there are formative (i.e., facilitating trainee development), normative (i.e., ensuring client safety, gatekeeping), restorative (i.e., protecting trainees from burnout), and potentially rehabilitative (i.e., remediation after professional violations) functions that enhance the primary goals of supervision (Bernard & Goodyear, 2019). In this process, clinical SORs fulfill a variety of roles, including educator, counselor, mentor, consultant, mentor, evaluator, administrator, advocate, crisis manager, and role model (Corey et al., 2021). Additionally, many clinical SORs may simultaneously be a SEE's administrative SOR, overseeing the various organizational dimensions of professional counseling development (Tromski-Klingshirn & Davis, 2007). Through an understanding of the purpose and function of supervision and the ways in which SORs fulfill various roles in the pursuit of supervision, clinical SORs can structure and evaluate the effectiveness of clinical supervision towards the preparation of novice BHPs for independent clinical practice. Ultimately, these roles may allow for SORs to effectively conceptualize ways they can use these different roles to meet the various needs of new clinicians in IPC settings, contributing to benefits that enhance the BHPs' preparation for independent practice.

Benefits of Clinical Supervision

Clinical supervision has been found to be related to a variety of benefits for novice BHPs across clinical settings. In a systematic review, clinical supervision has been found to be effective at increasing the self-awareness and self-efficacy of BHPs, aligning with constructs in the IDM outlining SEE development from less to more advanced stages (Lohani & Sharma, 2022; Stoltenberg & McNeill, 2010). Additionally, clinical supervision interventions have been found to assist in reducing novice BHP anxiety, a frequent concern that may be related to

adverse clinical and supervisory outcomes (Ellis et al., 2015) and is indicative of lower developmental stages (Stoltenberg & McNeill, 2010). Development of SEEs' clinical skills is an important dimension for novice BHPs, with researchers finding supervision enhances SEEs' skills in evidence-based counseling approaches, such as Cognitive Behavior Therapy (Alfonsson et al., 2020) and Motivational Interviewing (Martino et al., 2016). Findings such as these highlight the importance of clinical supervision in the pursuit of personal and professional development that may ultimately impact the clinical practice of the novice BHP.

While providing specific supervisory interventions to enhance SEEs' clinical skills is an important dimension of clinical supervision, the importance of the supervisory relationship cannot be overstated, as supervision is conceptualized as both an intervention and a relationship (Bernard & Goodyear, 2019; Corey et al., 2021). Specifically for novice therapists, the supervisory working alliance has been found to be indicative of clinical effectiveness when considering client and SEE perceptions of therapeutic alliance and clinical outcomes (DePue et al., 2020). Additionally, a meta-synthesis of SEEs' experiences in clinical supervision found that the supervisory relationship was related to increased clinical confidence and self-awareness, collaborative learning, and normalization of various experiences as a BHP (Wilson et al., 2016). These findings further highlight the conceptualization that supervision is both a relationship and intervention (Bernard & Goodyear, 2019). By ensuring a supervisory working relationship that is perceived and rated positively, novice BHPs may be able to enhance clinical outcomes in their patients.

A final crucial dimension of the impact of clinical supervision on SEEs is related to burnout, an important dimension of the Quadruple Aim (Bodenheimer & Sinsky, 2014). For the average BHP, researchers have found moderate to high levels of emotional exhaustion and

depersonalization, indicating common experiences of exhaustion, overextension, depletion, and disconnection (O'Connor et al., 2018). This is concerning since BHP burnout has been found to be related to lower levels of patient engagement and reduced clinical effectiveness (Yang & Hayes, 2020). However, supervision, when paired with other work-related factors, has been identified as a potential protective factor for BHPs (O'Connor et al., 2018).

For novice BHPs transitioning to clinical practice in IPC settings, the provision of clinical supervision may be instrumental in facilitating personal and professional development, enhancing direct clinical skills, and reducing the risk of burnout. Therefore, it becomes important to ensure that supervision provided to new clinicians in IPC settings meets their needs while simultaneously attending to the overarching purpose of supervision.

Behavioral Health Supervision in Primary Care

Despite recognition that clinical supervision for novice BHPs in primary care settings is a vital component of training (Dobmeyer et al., 2016), there is a lack of empirical research on clinical supervision for BHPs in IPC. Researchers have identified a variety of challenges associated with supervision in the IPC setting, including a lack of SOR competence, a lack of SEE competence, and unique ethical challenges associated with behavioral health services in primary care settings (Ogbeide et al., 2023a). In response, supervision competencies have been identified for SORs within IPC settings following the PCBH model, highlighting primary care knowledge, clinical supervision skills, and clinical SOR development (Ogbeide & Bayles, 2023). Additionally, guidelines have been developed for integrated care SOR selection, creation of the supervision contract, documenting personal practice beliefs and practices as they relate to IBH, and conceptualizing clinical supervision within the context of the site's level of integration (see Heath et al., 2013) to promote consistency in training programs (Pratt & Lamson, 2011; Pratt &

Lamson, 2012). Despite being crucial, these developments may not be sufficient to ensure that supervision provided to new BHPs in IPC settings meets their needs, as unsatisfactory supervision in various IBH settings has been a salient concern for BHPs (Kracen et al., 2023; Li et al., 2022). Therefore, it becomes important to understand the considerations and state of supervision for BHPs embedded in IPC settings.

Primary Care Supervision Considerations

When attempting to understand novice BHP needs in supervision, considering the context in which supervision occurs is imperative. Therefore, it benefits clinical SORs to conceptualize considerations for the delivery of supervision in IPC. Edwards and Patterson (2006) highlight four foundational skills for the effective provision of clinical supervision in IPC settings: 1) understanding the culture of medicine and primary care; 2) understanding the SEE's placement, roles, and skills within in the primary care setting; 3) exploring the interconnectedness of patients' biological and psychosocial presentations; and 4) and attending to the unique challenges and stressors encountered by novice BHPs in IPC settings. These skills have been echoed by other researchers, who highlighted the importance of an intimate knowledge of the nuances and requirements of BHPs in the primary care setting (Dundon et al., 2011), matching the context and culture of primary care (Mancini et al., 2019), and attending to interprofessional and inherently collaborative dimensions of IBH settings (Lindblad, 2021) within clinical supervision.

Particularly within the IPC context, clinical supervision may be provided in various formats, including traditional models of individual and weekly supervision, and those that mirror preceptor models in medical training (Mancini et al., 2019). Mancini and colleagues propose the use of live clinical supervision in IPC settings, using the Patient Ask Recommend See Evaluate (PARSE) model that mirrors medical precepting for physicians (2019). In this model of clinical

supervision, SORs provide live supervision for each patient that is seen in the primary care setting, matching the fast-paced, time-limited context of primary care. In practice, the PARSE model allows for SORs to directly assist the novice BHP with conceptualizing the patient and their concerns, explore targeted treatment options, observe and assist the trainee in providing direct clinical interventions, and evaluate trainee clinical skill and effectiveness. This may be most effective when paired with traditional supervision, in which the SOR and SEE meet weekly for at least one hour, and group supervision, particularly if there are multiple BHPs-in-training at the same primary care site (Mancini et al., 2019; Ogbeide et al., 2023a).

Current State of Behavioral Health Supervision in Primary Care

While the literature specifically exploring the impact of clinical supervision for BHPs in IBH settings is limited, there have been promising findings related to focused supervision for BHPs addressing biopsychosocial concerns in IBH settings. Psychologists receiving clinical supervision for practice in psycho-oncology indicated using supervision to enhance their conceptualization of their professional identity, interdisciplinary collaboration skills, and understanding of psycho-oncology and treatment (Kracen et al., 2023). Additionally, BHP SEEs indicated using supervision to process emotionally laden experiences in their work in psycho-oncology (e.g., countertransference, managing patient deaths), enhance their self-care, and managing various social and ethical issues that may be prevalent within psycho-oncology (Kracen et al., 2022). These findings indicate the helpfulness of focused clinical supervision in navigating complex biopsychosocial concerns within IBH settings.

Despite these benefits, SEEs in Kracen and colleagues' (2023) study also indicated various unmet needs in supervision, including unexplored content related to professional issues (e.g., difficult conversations with colleagues) and psycho-oncology-specific dimensions (e.g.,

termination of counseling with cancer survivors), feeling unheard by their clinical SOR, and perceiving their SOR as inaccessible due to the busyness of IBH settings. This aligns with other researchers' findings indicating concerns of counselors in IBH settings, citing that they received unsatisfactory supervision, contributing to various challenges they may experience in these settings (Li et al., 2022). It becomes important to recognize the needs of novice BHPs in IPC settings so that clinical SORs can ensure supervision adequately prepares them for independent practice within the primary care context.

The Current Study

Pratt and Lamson (2011) indicate the importance of clinical supervision for interns and new BHPs as they integrate into new and nontraditional behavioral health settings, such as primary care. Despite this, research has indicated that BHPs in primary care settings may be receiving clinical supervision that is unsatisfactory and does not meet the needs of novice BHPs (Kracen et al., 2023; Li et al., 2022). This has implications for the various dimensions of the Quadruple Aim identified by Bodenheimer and Sinsky (2014), potentially contributing to poorer clinical outcomes and patient satisfaction, increased healthcare spending for individual patients and organizations, and decreased levels of provider satisfaction and wellness. Therefore, it becomes important for behavioral health SORs in IPC settings to be aware of the wide range of supervisory needs of novice clinicians so that they may enhance the training and preparation of the IBH workforce. In the current study, I propose a consensus-driven exploration of novice BHPs' perceptions of their supervisory needs when receiving clinical supervision in IPC settings.

Chapter Summary

The integration of behavioral health into primary care has been found to be an effective model of care when considering the Quadruple Aim of healthcare: 1) enhancing patient

outcomes; 2) enhancing patient satisfaction; 3) enhancing cost-effectiveness of healthcare; and 4) enhancing provider wellness and satisfaction (Bodenheimer & Sinsky, 2014). Given that primary care is conceptualized as the de facto behavioral health treatment setting in the United States (Kessler & Stafford, 2008), BHPs integrated in these settings may be in an ideal position to provide behavioral health services as part of an interdisciplinary healthcare team to meet the goals of the Quadruple Aim. In this process, clinical supervision remains a vital component of training for BHPs in an IPC setting, given its conceptualization as a teaching method that is distinctive and crucial to behavioral health professions (Bernard & Goodyear, 2019). To enhance the training and preparation of BHPs, supervision that adequately prepares novice BHPs to practice as an autonomous member of the interdisciplinary primary care team. This study seeks to enhance the literature on clinical supervision in IPC settings by exploring the needs of novice BHPs integrated into primary care contexts.

CHAPTER THREE

METHODOLOGY

In this chapter, I will propose the methodology of this study. First, I will provide the research questions that will guide the research design. Afterwards, I will explore the primary components of the Delphi methodology, including the rationale for this mixed methods design, the important elements of a Delphi study (e.g., the Delphi panel, stages), and the procedures for data collection and analysis from qualitative and quantitative perspectives. Finally, I will provide a brief exploration into the general ethical considerations of this study and their potential representation in the current study.

Research Question

Through this study, I aim to address the following research question: What do novice behavioral health clinicians in Integrated Primary Care settings identify to be their most pertinent needs in clinical supervision?

Conceptual Framework of the Current Study

In this study, I followed ontological and epistemological ways of conceptualizing the design, implementation, analysis, and interpretation of this research. I approached this research from social constructivist and postpositivist paradigms (Creswell & Creswell, 2018). Social constructivism is grounded in the idea that individual reality is shaped due to interactions with the world and those around the individual (Creswell & Creswell, 2018; Dawadi et al., 2021). Due to the inherent exploratory nature of the Delphi methodology (Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009), an orientation and appreciation for the constructed realities of Delphi panelists becomes vital. In addition, Delphi panelists will interact with each other indirectly through numerous anonymous surveys (Strear et al., 2018), in which the perceptions of other

panelists' perspectives will be available. As iterated in a seminal Delphi text, "that one important product of each Delphi panel is the reality that is defined through its interaction" (Linstone & Turoff, 1975, p. 35). Through a social constructivist paradigm, I believe I was better able to better conceptualize items receiving consensus as an interaction between panelists' individual lived experiences and indirect contact with other panelists' experiences. Using a social constructivist paradigm, I addressed novice clinicians' perceptions of their needs for supervision in IBH settings. This perception will be inherently tied to their own lived experiences and interactions with peers, supervisors, and other panelists as they navigate being a novice clinician in an untraditional behavioral health setting.

Post positivism is a paradigm of research which aims to find the balance between objective and subjective realities in research (Dawadi et al., 2021). In this conceptual paradigm, researchers dispute preconceived notions of absolute knowledge and/or truth, instead recognizing that truth may be contextual (Creswell & Creswell, 201; Dawadi et al., 2021; Panhwar et al., 2017). In this manner, researchers view knowledge as provisional, recognizing the potential to be influenced by participants and the methods being utilized (Panhwar et al., 2017). The use of post positivistic thinking is appropriate for mixed methods research, as it allows for subjective experiences to be made objective (Dawadi et al., 2021), as is the case for an exploratory mixed methods approach. Through a postpositivist paradigm, I conceptualized reality and knowledge as an intricate balance between subjective and objective, in which there are truths to be found, yet none are absolute and must be understood within the context of the research and participants. Together, conceptualizing this research from social constructivist and postpositivist paradigms allowed for me to understand the results as grounded within the perspective that the realities and findings are not indicative of absolute truth of all novice clinicians and supervisees in IPC

settings, yet are grounded within the objective measure of subjective experiences, ultimately influenced by participants' and my own experiences and social interactions.

Delphi Methodology

In this study, my aim was to gather consensus on what novice behavioral health clinicians perceive to be their most pressing needs in supervision when practicing in IBH settings. Based on my conceptual framework and purpose of this study, I conducted a Delphi study, an exploratory sequential mixed-methods research design with the goal of gathering consensus on a topic(s) of interest (Hsu & Sandford, 2007). The Delphi method was originally developed by the RAND Corporation in the 1950s to effectively speculate the effects of technology on wartime efforts, using various rounds of anonymous communication and feedback between military experts (RAND, n.d.; Nasa et al., 2021). Rieger (1986) highlighted the secretive nature of the Delphi method in the early stages of its design, likely due to the context of its creation. Since the declassification of this methodology in the 1960s, the Delphi design has evolved significantly, initially transitioning to corporate forecasting (Rieger, 1986; Yousuf, 2007) and then evolving towards a variety of fields. Currently, the Delphi method is used by researchers in a variety of fields, including healthcare, education, marketing, and political science, among others (RAND, n.d.; Taghipoorreyneh, 2023). Since its initial creation, the Delphi method has been consistently used as a research design that can be applied to a variety of professions and topics that have limited empirical history.

The Delphi methodology is an exploratory sequential mixed methods design with various rounds of qualitative and quantitative data collection and analysis (Creswell & Creswell, 2018; Iqbal & Pipon-Young, 2009). Data collection involves several rounds of structured, anonymous communication between experts in the topic(s) of interest (Hsu & Sandford, 2007; Iqbal &

Pipon-Young, 2009; Strear et al., 2018). The Delphi methodology is an ideal research design when exploring topics that are disputed and/or undefined, lack a strong literature base, and are challenging to study using precise statistical methods (Grisham, 2009; Iqbal & Pipon-Young, 2009; Ogbeifun et al., 2016). Additionally, it allows for a wide range of stakeholders and experts to be involved in the topic(s) of interest while preserving anonymity to reduce severe disagreements and social pressures (Grisham, 2009) and when geographic, financial, and/or time constraints limit the ability to conduct in-person discussion (Hsu & Sandford, 2007; Ogbeifun et al., 2016). Towards this end, Delphi studies allow for stakeholders and experts to generate consensus, expose underlying perceptions and assumptions, and explore the wide range of aspects related to the topic(s) of interest (Hsu & Sandford, 2007).

Within the counseling field, the Delphi methodology has been identified as "an effective mechanism for elucidating expertise of professionals in all facets of the field to inform intentional practice" (Strear et al., 2018, p. 57). This allows counseling researchers to provide other counseling professionals across specialization (e.g., research, clinical, supervision, education) with practical results for improving their practice, grounded in the experiences and knowledge of other counselors. The Delphi method has been used by counselors to better conceptualize topics pertinent to the profession, including research competencies (Wester & Borders, 2014), teaching competencies (Swank & Houseknecht, 2019) competencies in counseling for children (Clark et al., 2022), American counselor educators engaging in multinational work (Smith et al., 2018), and supervision competencies (Neuer Colburn et al., 2015). Within IBH, researchers have used the Delphi method to explore various topics of interest, including clinician fidelity to the Primary Care Behavioral Health (PCBH) model (Beehler et al., 2013), a comprehensive definition of behavioral medicine (Dekker et al., 2021),

competencies and skills for primary care providers and residents (Martin et al., 2019; Martin et al., 2022a), conceptualizations of productivity in PCBH settings (Martin et al., 2022b), and PCBH supervision competencies (Ogbeide & Bayles, 2023). As seen by examples above, the Delphi design is an appropriate methodology to use within counseling and IBH research.

Research Design

To address the research question, I conducted this Delphi research study in five distinct phases (Iqbal & Pipon-Young, 2009; Neuer Colburn et al., 2015; Strear et al., 2018): 1) identification and recruitment of the Delphi panel; 2) survey development and pilot testing; 3) round one, consisting of initial qualitative data collection and analysis based on Delphi panelists' lived experiences and knowledge; 4) round two, consisting of initial development of consensus via quantitative collection and analysis paired with qualitative clarification and/or restatement of items from round one; and 5) round three, consisting of final member checking and quantitative analysis of items to confirm consensus.

Throughout all phases of this design, I engaged in frequent email communication between myself and the expert panelists as an important component of effective Delphi research (Grisham, 2009). I believe this positively contributed to the results of the study by reducing attrition and enhancing expert panelist engagement in the research process. Additionally, I invited two doctoral co-researchers to assist me in the analysis of qualitative data throughout the study to enhance the credibility and trustworthiness of the findings. Aiming at reducing bias through a collaborative analysis procedure, I provided orientation to both doctoral co-researchers by introducing the study rationale and methodology as I directly supervised them in the research process.

Phase 1: Identification and Recruitment of the Delphi Panel

Within this methodology, the identification of experts for the Delphi panel is conceptualized as a crucial component that sets the stage for the whole study (Grisham, 2009; Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009; Nasa et al., 2021; Wester & Borders, 2014). It is recommended that Delphi panelists share a common identity, knowledge, experience, and ability to influence policy and/or practice (Strear et al., 2018), highlighting the importance of a group of expert panelists that are connected by the topic under exploration. The number of panelists for a Delphi panel varies, ranging from three to 1000 panelists (Iqbal & Pipon-Young, 2009; Nasa et al., 2021; Ogbeifun et al., 2016), with Linstone and Turoff (1975) identifying 10 to 50 as an appropriate number. I initially proposed recruiting between 10 and 25 expert panelists for this study, with this panel size being successfully used in prior Delphi studies related to counseling and IBH (Beehler et al., 2013; Martin et al., 2019; Martin et al., 2022b; Wester & Borders, 2014). In total, 16 expert panelists were invited to participate and 12 participated in all three rounds of this study. This final panel number lies within acceptable sampling for Delphi studies (Linstone & Turoff, 1975).

For this study, I utilized inclusion criteria to be considered as an expert panelist for this study, as purposive sampling is the preferred method for recruitment in Delphi designs (Linstone & Turoff, 1975; Neuer Colburn et al., 2015; Wester & Borders, 2014). Additionally, I engaged in snowball sampling to enhance the recruitment of potential panelists. Snowball sampling, when paired with purposive sampling, is an appropriate recruitment method for Delphi studies due to the possibility that experts in a topic may have personal and professional relationships with other experts (Iqbal & Pipon-Young, 2009; Strear et al., 2018).

To be conceptualized as an expert panelist and included in this study, I specified that expert panelists needed to meet the following criteria: 1) being a behavioral health professional

in training (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education; (2) having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting; and 3) having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting.

The first inclusion criterion was chosen to promote recruitment of behavioral health clinicians who can reasonably be considered novice. Novice professionals can be conceptualized as individuals who are new to the professional work but also have appropriate knowledge and experience to understand the needs of the work (Kemer, 2020). Students who are in graduate training programs receive the foundational skills, knowledge, and experiences to become a licensed clinician, highlighting their novice status in the behavioral health field. Licensure status (e.g., Licensed Professional Counselor, Licensed Clinical Psychologist) can be conceptualized as a significant professional event emphasized by a transition from monitored to independent clinical practice (American Counseling Association [ACA], n.d.). This transition from unlicensed to licensed clinician status takes years of postgraduate work and may signify an evolution from novice to experienced clinician, as they have met all necessary requirements set by their respective licensing board to practice as an independent clinician. Therefore, recruiting behavioral health students who are within the clinical placement of their graduate training or have completed their graduate training within six months of participation may ensure that expert panelists in this study are novice BHCs.

The choice to invite behavioral health clinicians from across professional identities is in accordance to calls for interdisciplinary healthcare research (Hesse-Biber, 2016; Smye & Frangi, 2021). Due to similar roles that the wide range of behavioral health clinicians may fulfill in IBH settings (Glueck, 2015; Ward et al., 2022), clinicians from differing professional identities may have more in common than different. These factors, paired with common characteristics of novice clinicians that transcend professional identity (Stoltenberg & McNeill, 2010), highlights the advantage of including the wide range of behavioral health clinicians that may benefit from this research. Prior Delphi researchers investigating IPC supervision have incorporated interdisciplinary panels with success, allowing for findings of the research to rise above differences in professional identity (Ogbeide & Bayles, 2023).

To promote clinician experience in IPC settings, I proposed the second inclusion criteria to be that all panelists have completed at least one semester of a supervised internship in an IPC setting or have completed their internship in an IPC setting and are no more than six months postgraduation. The provision of clinical services in IPC often spans a variety of responsibilities, with assessment, case conceptualization, clinical intervention, referral coordination, and interprofessional consultation and collaboration being important for behavioral health clinicians in integrated care (Dobmeyer, 2018; Glueck, 2015). This inclusion criterion is meant to promote exposure to the roles and responsibilities of behavioral health clinicians in IPC settings, allowing potential panelists to have the lived experience of a BHC in these spaces. The criteria of completion of at least one semester of internship and no more than six months postgraduation was indicated to promote identification as a novice BHC. Less time in internship may contribute to panelists who do not have the needed experience to conceptualize their supervisory needs, while greater than six months postgraduation may contribute to panelists being in more advanced

stages of professional development. This, paired with being a behavioral health student or pre-licensed clinician, contributes to the final inclusion criterion.

The final inclusion criterion chosen for this study was related to having weekly individual and/or triadic supervision during current or prior clinical practice as a new clinician in IPC settings. Due to my emphasis on the supervisory needs of novice clinicians in IPC settings, the final criterion allows for me to gather information on the novice clinicians' lived experiences as a supervisee. Through this process, expert panelists can contribute to the study by drawing upon their own and their peers' experiences receiving supervision in IPC settings. These three inclusion criteria promoted panelist identification as a novice behavioral health, experience providing direct clinical services in IBH settings, and experience receiving clinical supervision within IPC settings.

Recruitment for this study occurred through three primary avenues: 1) directly contacting potential panelist who meet inclusion criteria via email; 2) contacting directors of educational and clinical programs with ties to IPC training and practice; and 3) posting recruitment messages on listservs associated with professional organizations with a history of IPC practice, training, and/or research (e.g., American Mental Health Counselors Association, Collaborative Family Healthcare Association). Direct communication with potential Delphi panelists is a common strategy for recruitment in Delphi studies (Martin et al., 2022a; Martin et al., 2022b; Neuer Colburn et al., 2015; Ogbeide & Bayles, 2023; Swank & Houseknecht, 2019). Therefore, direct email contact with potential panelists is an appropriate recruitment method to gather the Delphi panel. Due to the inclusion criteria calling for novice clinicians, direct communication with clinical and educational directors of programs known for training IPC clinicians may have been an effective way to recruit new clinicians who have received supervision in IPC settings. Finally,

recruitment through professional membership organizations with ties to IPC research and advocacy allowed for a wider net to be cast, potentially recruiting individuals outside of my own professional network.

Due to the time commitment and numerous rounds of surveys associated with Delphi studies, attrition is an important consideration for this methodology and may negatively impact the results of the study (Ogbeifun et al., 2016; Strear et al., 2018). Therefore, I engaged in a recruitment period that lasted for eight weeks (i.e., October 3rd, 2023, to December 1st, 2023), until 16 expert panelists who met inclusion criteria were recruited. This strategy, paired with frequent communication between panelists and me as the researcher (Grisham, 2009; Strear et al., 2018), may reduce attrition and contribute to more meaningful outcomes by standardizing the timeframe for the various rounds of data collection and analysis.

Phase 2: Survey Development and Pilot Testing

After the recruitment of the Delphi panel, I created the survey for Round 1. This initial survey was open-ended, in alignment with recommendations for classical Delphi study and where the purpose is to gather qualitative data through statements and ideas generated by expert panelists related to the topic under investigation (Grisham, 2009; Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009). The survey was created after "a detailed literature review, consultation with relevant individuals and consideration of the aims of your Delphi study" (Iqbal & Pipon-Young, 2009, p. 599).

Upon creation of the survey for Round 1, I engaged in pilot testing of the survey, an important component of survey development (Creswell & Poth, 2018). In this proposed Delphi study, pilot testing allowed for me to enhance methodological effectiveness by receiving feedback to improve the clarity, readability, and appropriateness of the survey (Grisham, 2009;

Iqbal & Pipon-Young, 2009; Strear et al., 2018). Towards this end, I sent out the survey draft to three individuals who have received supervision in IPC settings but are not currently providing direct clinical services in IPC. I encouraged pilot testers to provide feedback on the survey items to be integrated into the final survey to be presented to the expert panelists during Round 1. Further information is discussed in Chapter 4.

Phase 3: Round 1 of Data Collection and Analysis

Round 1 of data collection included dissemination of the demographic and initial statement survey (Iqbal & Pipon-Young, 2009). Data collection and analysis followed general descriptive statistical analysis (Salkind & Frey, 2020) of pertinent demographic data and open and axial coding procedures (Corbin & Strauss, 2015) outlined below.

Data Collection. The purpose of this survey was to gather information about the expert panelists and to begin the process of creating panelist statements and ideas related to the needs of new clinicians in IBH settings. The creation and dissemination of this survey was done through Qualtrics, an online research software (Qualtrics, n.d.). The survey included nine multiple choice, multiple answer, and/or short answer questions exploring expert panelists' demographic information, including age, racial identity, gender identity, professional identity, professional standing as a graduate student or clinician accruing licensure hours, months of experience providing direct clinical services in IPC settings, months of supervision received during clinical practice in IPC settings, and congruence of supervisor-supervisee professional identity (see Appendix C). By gathering this demographic information, it was intention to get an accurate conceptualization of the ways in which expert panelists' identities and experiences align with the purpose of this study and to contextualize the statements provided through their lived experiences.

This survey also included one question with the prompt for expert panelists to provide up to 50 statements in sentence format pertaining to the topic under investigation. This question was open-ended to encourage expert panelists to brainstorm, allowing their lived experiences to guide the generation of statements and ideas (Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009). This question specifically prompted expert panelists to explore their perceptions related to the supervisory needs of new clinicians in IPC settings. To help structure this prompt, I provided examples of domains and statements in which answers may be grounded, including clinical, nonclinical, administrative, personal, and professional needs of supervisees in an IPC setting. As a result of this question, expert panelists statements were gathered and analyzed to present to the Delphi panel during Round 2 (see Appendix C; Hsu & Sandford, 2007; Nasa et al., 2021).

Data Analysis. Data analysis in this stage of the research followed both quantitative and qualitative procedures, with qualitative data analysis taking the forefront. Demographic information was analyzed using descriptive statistical analyses, focusing on measures of central tendency (e.g., mean, median, percentage) and variance (e.g., standard deviation; Salkind & Frey, 2020). Descriptive statistics are used in research to "calculate, describe, and summarize research data in a logical, meaningful, and efficient way" (Vetter, 2017, p. 1797), allowing for us to accurately conceptualize the identities and quantifiable experiences of the expert panelists.

Qualitative analysis of statements generated by the expert panel in response to the open-ended question will be the focus of Round 1. This analysis was conducted by me and one doctoral co-researcher, following open and axial coding processes (Corbin & Strauss, 2015; Strauss, 1987), a qualitative analysis procedure previously used by counseling researchers in Delphi studies (Neuer Colburn et al., 2015). The first step in this strategy was to familiarize ourselves with the data (Goodman-Scott & Cholewa, 2023), allowing for myself and the other

members of the research team to have an in-depth knowledge and awareness of the expert panelists' ideas. This was done by each researcher reading and re-reading the statements generated by the expert panelists.

Afterwards, we engaged in open coding procedures, which are exploratory and seek to initially categorize data into concepts (Corbin & Strauss, 2015; Creswell & Poth, 2018). These initial emergent themes are provisional and used to further conceptualize and reduce the data so that the expert panelists' ideas are thoroughly represented within the final codes (Corbin & Strauss, 2015; Strauss, 1987; Williams & Moser, 2019). Within the process of open coding, preservation of the experts' language becomes an important task as to not assume the meaning behind their statements (Strear et al., 2018). This was done by collapsing statements into thematically and conceptually similar groups, comparing concepts between and withing statements, and keeping memos (Corbin & Strauss, 2015; Williams & Moser, 2019).

The next step in the process was axial coding, in which open codes are further collapsed and combined to represent larger conceptualizations of the topic of interest (Goodman-Scott & Cholewa, 2023; Neuer Colburn et al., 2015). This allowed us to gather a comprehensive understanding about the relationships, similarities, and distinctions between the categories and subcategories (Strauss, 1987). While the purpose of open coding is the identification of emerging themes, axial coding provided us the opportunity to clarify and categorize themes more accurately (Williams & Moser, 2019). This was done through an examination of the context in which the data is presented, consistent comparison of emerging and solidifying themes, and thorough examination of each line of text and category to ensure researcher connection to the data (Goodman-Scott & Cholewa, 2023; Strauss, 1987; Williams & Moser, 2019). In Delphi research, this axial coding process may translate to the collapsing and combination of various

expert panelists' ideas into a series of coherent, distinct statements (Neuer Colburn et al., 2015). In this process, it remains a priority to preserve expert panelist language (Strear et al., 2018).

After open and axial coding procedures were completed, the coded data was provided to the third member of the research team for her to review and leave feedback on the correctness-of-fit for the analyzed statements and themes. This aligns with practices of triangulation, in which various researchers are utilized to ensure methodological and analytical credibility (Goodman-Scott & Cholewa, 2023). Upon receiving the feedback on the coded data, the initial two members of the research team amended statements that had auditor feedback as appropriate.

At the conclusion of qualitative data analysis in Round 1, we were left with a series of statements grounded in expert panelists' ideas and perceptions related to novice clinicians' supervisory needs in IBH settings. These statements were distinct, representing unique, nonrepetitive responses provided by the expert panelists (Neuer Colburn et al., 2015). They were used in Round 2 to start the process of garnering consensus on the supervisory needs of novice behavioral health clinicians in IPC settings (Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009).

Phase 4: Round 2 of Data Collection and Analysis

Round 2 of this study began the process of gathering consensus on items and statements generated by expert panelists during Round 1 (Iqbal & Pipon-Young, 2009). This was done by analysis of quantitative data to indicate statistical consensus and qualitative data to amend statements that did not reach statistical consensus in Round 1 (Iqbal & Pipon-Young, 2009; Neuer Colburn et al., 2015; Yousuf, 2007).

Data Collection. The purpose of this survey was to start the process of gathering consensus on what expert panelists conceptualize to be the supervisory needs of novice clinicians

in IBH settings. The survey was grounded in the statements generated during Round 1 data collection and analysis, as per best practices for Delphi studies (Hsu & Sandford, 2007). The length of this survey was dependent on the number of unique, nonredundant statements that arose from the first round. Creation of the survey and recording of data was done using Qualtrics (Qualtrics, n.d.). As the primary researcher, I provided expert panelists access to the Qualtrics survey via a direct email using the blind carbon copy (bcc) feature.

Each item in this survey incorporated a unique statement related to the topic of the research, a six-point Likert style indicator of agreement, and open-ended spaces for expert panelists to indicate comments related to suggestions for revisions, additions, or removal of the statement if they did not strongly or moderately agree (Swank & Houseknecht, 2019; Wester & Borders, 2014). Likert-style questions have historically been conceptualized as an ideal way to assess individuals' agreement and/or disagreement with an item (Sullivan & Artino, 2013) and have been used extensively in prior Delphi studies to achieve consensus (Martin et al., 2019; Neuer Colburn et al., 2015; Ogbeide & Bayles, 2023; Swank & Houseknecht, 2019; Wester & Borders, 2014). I used a six-point Likert-scale for each item (1 = strongly agree, 2 = moderately agree, 3 = slightly agree, 4 = slightly disagree, 5 = moderately disagree, 6 = strongly disagree; Neuer Colburn et al., 2015; Swank & Houseknecht, 2019). The use of a six-point Likert scale may allow for expert panelists to indicate a greater range of agreement versus disagreement when compared to a traditional four or five-point Likert-scale. An open-ended prompt at the end of each statement is an important component of subsequent rounds of the Delphi methodology, as it allows for expert panelists to indicate their rationale for disagreement and suggestions for revising, adding, or removing statements for future consensus (Swank & Houseknecht, 2019; Wester & Borders, 2014). At the end of the survey, participants were provided with a copy of the

list of 65 statements with additional open-ended spaces to suggest new statements that they perceived as unrepresented in the data.

Data Analysis. In Round 2, we began the process of highlighting consensus on statements identified as pertinent to the expert panelists. An important task prior to dissemination and data analysis in Round 2 was to identify what was conceptualized as statistical consensus (Iqbal & Pipon-Young, 2009; Nasa et al., 2021; Neuer Colburn et al., 2015). While researchers have highlighted discrepancies in guidelines for conceptualizing consensus in Delphi studies (Ogbeide & Bayles, 2023; Wester & Borders, 2014), the median and interquartile range (IQR) have been identified as appropriate statistical indicators of consensus by accounting for central tendency and dispersion of expert panelists' agreement (Neuer Colburn et al., 2015; Swank & Houseknecht, 2019; Wester & Borders, 2014). The median is defined as the middle number in a set of scores and the IQR is defined as the range between the first and third quartiles in a set of scores (Salkind & Frey, 2020; Vetter, 2017). We identified *a priori* definitions of consensus as a median of 2.00 or less and an IQR of 1.00 or less, as previously identified as appropriate in prior counseling Delphi research (Swank & Houseknecht, 2019). Statistical analysis will be conducted using SPSS Statistics software (IBM, n.d.). For statements that achieve statistical consensus during Round 2, no modifications or suggestions for revisions will be applied.

For statements that do not meet predetermined benchmarks for consensus and new statements that were suggested at the end of the survey, qualitative analysis for Round 2 followed the same analysis procedures as outlined for Round 1, with two members of the research team analyzing the new uncoded data. We engaged open and axial coding to identify pertinent themes in feedback provided by expert panelists (Corbin & Strauss, 2015; Goodman-Scott & Cholewa, 2023; Strauss, 1987). Triangulation procedures were maintained using a third

researcher to ensure credibility of the qualitative analysis. Results from qualitative analysis in Round 2 were incorporated into statements provided to expert panelists for the third and final round of this study.

Phase 5: Round 3 of Data Collection and Analysis

Round 3 was the final round of the study, adhering to recommendations and guidelines for managing panelist fatigue and attrition in Delphi designs (Iqbal & Pipon-Young, 2009; Neuer Colburn et al., 2015). Expert panelists were provided with one final opportunity to indicate quantitative consensus on items that were amended and/or added from Round 2 (Hsu & Sandford, 2007; Iqbal & Pipon-Young, 2009; Strear et al., 2018). As the conclusion of this round, research team possessed a list of unique statements on the needs of novice BHCs in IPC settings.

Data Collection. Data collection for this final round followed the same procedures from Round 2. The creation of this final survey was grounded in expert panelists' recommendations for revision, addition, and/or removal of items from Round 2 (Hsu & Sandford, 2007), done via Qualtrics (Qualtrics, n.d.). I provided expert panelists with the direct link to the Qualtrics survey via individualized emails. In these individualized emails, I gave expert panelists information related to their degree of agreement versus disagreement for each remaining item (Iqbal & Pipon-Young, 2009). This may have provided expert panelists with an important context for examining their beliefs and perspectives as they reevaluate the remaining items. All items represented during Round 3 were assessed for consensus using the same Likert-scale utilized during Round 2. Due to the purpose of Round 3 being to finalize consensus, no open-ended prompts for revisions or additions were provided. At the conclusion of this round, participants received a $50 Amazon eGift Card as compensation for participation in this study.

Data Analysis. Data analysis followed the same quantitative procedures conducted during Round 2. The indicators for consensus determined *a priori* were maintained for the final round of this study, with consensus being defined as a median or 2.00 or less and an IQR of 1.00 or less. All statistical analyses were conducted using the SPSS Statistics software (IBM, n.d.). Any statements that did not reach the predetermined benchmarks for consensus are separate from statements that did meet the *a priori* definition of statistical consensus in the data table. At the conclusion of this round, possessed the final list of statements that achieved consensus by expert panelists surrounding the supervisory needs of novice clinicians in IBH settings.

Validity and Reliability in Delphi Studies

Within the Delphi methodology, the creation of the Delphi panel is conceptualized as one of the most important components to ensuring validity of the research (Wester & Borders, 2014). Therefore, I created rigorous inclusion criteria to ensure that the expert panelists have the experience and knowledge of IPC supervision from a supervisee's perspective, and the ability to critically examine and reflect upon their perceptions of IPC supervision. The ability of expert panelists to continuously identify and reevaluate their perspectives is an important component of Delphi studies (Iqbal & Pipon-Young, 2009), potentially contributing to a more valid study. Additionally, the validity of Delphi studies is enhanced when the first round incorporates an open-ended question, allowing members of the Delphi panel to brainstorm and explore their perceptions related to the topic under investigation (Swank & Houseknecht, 2019).

Due to the balance of both quantitative and qualitative data analyses in the Delphi methodology, it becomes important to engage in appropriate trustworthiness strategies to reduce researcher bias and ensure the validity of the qualitative procedures (Creswell & Poth, 2018; Goodman-Scott & Cholewa, 2023; Wester & Borders, 2014). To enhance the validity and

credibility of this study, I engaged in a variety of trustworthiness strategies, including having a research team under my supervision for the qualitative research procedures, researcher reflexivity strategies (e.g., identification of experiences and biases), peer debriefing, triangulation of researchers, consultation with an external reviewer (i.e., dissertation chair and methodologist), prolonged engagement with the raw and coded data, field notes, and member checking via email as applicable (Goodman-Scott & Cholewa, 2023; Neuer Colburn et al., 2015; Strear et al., 2018).

Researcher Reflexivity

Reflexivity has been identified as a vital component of qualitative research (Goodman-Scott & Cholewa, 2023). Due to the qualitative components of Delphi research, it becomes important that I, along with my research team, engage in appropriate reflexivity. As the primary researcher, I am a 26-year-old Cisgender white male. I am a third-year Doctor of Philosophy (Ph.D.) candidate in Education – Counseling. I have experienced social privilege in my access to comprehensive, quality healthcare services. Additionally, I have personal and professional ties to the research topic, as I have been both a clinical mental health counseling supervisor and supervisee within IPC settings during my doctoral studies at Old Dominion University.

The second researcher is a 30-year-old Cisgender white female and is a second-year Ph.D. student in Education – Counseling. During the time of this project, she was actively receiving supervision as a clinician working towards her counseling licensure and was providing supervision for master's level interns at an IBH clinical site. As the study is looking into supervision in integrated behavioral health settings, it is important to acknowledge her professional background as a Registered Nurse and her increased familiarity with the medical setting, roles, and responsibilities.

The third researcher is a 23-year-old Cisgender white female. She is a first year Ph.D. student in Education – Counseling. She has experience as a Resident in Counseling in private practice and has not had experience as a clinician in IPC settings or as a supervisor.

Research team members' bracketing of experiences, opinions, and expectations occurred collaboratively after recruitment and before the first round of qualitative data analysis. Debriefing also occurred collaboratively at the conclusion of each data analysis meeting and reflexivity journaling was completed independently afterwards.

Ethical Considerations

I completed an Institutional Review Board (IRB) application that was approved prior to conducting the study and consulted with my dissertation committee to ensure methodological appropriateness and adherence to ethical standards. To attend to the wide range of ethical considerations in counseling research, including research responsibilities, rights of the expert panelists, managing boundaries, reporting results, and preparing for future publications and presentations, I frequently consulted with Section G of the ACA (2014) code of ethics and my dissertation committee. I provided expert panelists with consent forms that represented the most recent information available and included the purpose and description of the research, names and contact information of pertinent members of the research team (i.e., myself, dissertation chair, doctoral co-researchers) inclusion and exclusion criteria, their rights as research participants (e.g., right to withdrawal, right to confidentiality and anonymity), and my contact information for questions, comments, and/or concerns. I stored all data using computer software that was available only to pertinent members of the research team (i.e., myself, dissertation chair, doctoral co-researchers) and protected using a two-factor authorization security feature. This study was funded by the Southern Association for Counselor Education and Supervision (SACES)

Research & Best Practice Grant for $500 (SACES, 2023), with each participant receiving a $50 Amazon eGift Card at the completion of the third survey, 10 of which were funded by the SACES grant and two of which were funded by me directly.

Chapter Summary

In this study, I utilized a classical Delphi methodology, a mixed-methods research design, to explore experts' perceptions on the supervisory needs of novice clinicians in IBH settings. Through the process, it was my aim to create an expert-generated list of statements that have achieved consensus through various rounds of structured, anonymous surveys. After recruiting the expert panel, creating the initial survey, and piloting the initial survey, I gathered both qualitative and quantitative data through three rounds of surveys. I, in collaboration with doctoral co-researchers, analyzed the qualitative data using open and axial coding procedures (Corbin & Strauss, 2015; Goodman-Scott & Cholewa, 2023; Strauss, 1987) and the quantitative data by computing the median and IQR (Vetter, 2017) using SPSS Statistics software (IBM, n.d.). These qualitative and quantitative analyses have been identified by prior researchers as effective and appropriate for Delphi studies (Neuer Colburn et al., 2015; Swank & Houseknecht, 2019; Wester & Borders, 2014).

CHAPTER FOUR

RESULTS

The purpose of this research study was to explore the supervisory needs of novice BHCs in IPC settings through a classical Delphi methodology with five distinct phases (i.e., Recruitment of the Delphi Panel; Survey Creation and Pilot Testing; Round 1; Round 2; Round 3). This effort was grounded in the research question: What do novice behavioral health clinicians in Integrated Primary Care settings identify to be their most pertinent needs in clinical supervision? In this chapter, I present the results of pilot test, expert panel demographic information, and Rounds 1 through 3. I end this chapter with a list culminating the final statements of supervisory needs that the expert panel identified as pertinent for new BHCs in IPC settings.

Pilot Test

Per best practices for Delphi studies (Grisham, 2009; Iqbal & Pipon-Young, 2009; Strear et al., 2018), I engaged in a pilot test of the survey for round one to ensure maximum readability and clarity of prompts. The pilot test was sent to four individuals who did not meet all inclusion criteria but had received clinical supervision for prior practice in an IPC setting, with three of these individuals responding. One was an advanced doctoral student in Counselor Education and Supervision who previously completed their master's level practicum and internship in an integrated general hospital and primary care clinic but was not completing clinical hours at the time of the study. The other two pilot testers were current advanced master's students who had previously completed a supervised practicum in an integrated general hospital and primary care clinics but was not finishing their internship in these settings. This pilot test allowed for

individuals who have expertise as clinicians and supervisees in IPC settings to provide their perspectives in the clarity and readability of the survey.

The pilot testers provided two comments indicating high levels of clarity and readability in the demographic section; no modifications were made to the demographic portion of the first survey. Pilot testers provided three pieces of feedback and three comments on the prompt eliciting expert panelists' perceptions of the supervisory needs of novice BHCs in IPC settings. Comments for this prompt indicated pilot tester perceptions of clarity in the instructions, including the helpfulness of stems (i.e., "which may include but is not limited to knowledge, clinical skills, nonclinical skills, professional development, personal development, etc.) to assist expert panelists in brainstorming. One feedback statement suggested modifications regarding how to use the text entry boxes. The final two feedback statements indicated suggestions for further assisting the expert panelists' brainstorming process, including brief examples of how statements could be worded and/or categorized. Each feedback statement was critically considered and incorporated into the final Round 1 survey provided to the expert panelists (see Appendix C).

Recruitment of the Delphi Panel

At the conclusion of the eight-week recruitment period, a total of 16 individuals responded to the research invitation and met the associated inclusion criteria. All 16 individuals received the Round 1 survey, in which 12 responded (n = 12) and were conceptualized as the expert panelists in the Delphi panel for this research (see Table 1). Prior researchers have identified an acceptable size of a Delphi panel to include between three and 50 expert panelists (Iqbal & Pipon-Young, 2009; Nasa et al., 2021; Linstone and Turoff, 1975; Ogbeifun et al., 2016), with 12 being an acceptable initial size for a Delphi panel.

Table 1

Delphi Panelist Demographic Information

Variable	% (n)	M	Mdn	SD	Range (L-H)
Age		28.67	28.00	4.62	18 (23-41)
Race					
Caucasian	66.7% (8)				
Black or African American	16.7% (2)				
Hispanic or Latino	8.3% (1)				
Asian	8.3% (1)				
Gender					
Cisgender Female	100% (12)				
Professional Identity					
Clinical Mental Health Counseling	25% (3)				
Clinical Psychology	58.3% (7)				
Clinical Social Work	8.3% (1)				
Marriage & Family Therapy	8.3% (1)				
Professional Standing					
Master's Student	25% (3)				
Doctoral Student	41.7% (5)				
Postdoctoral Fellow	25% (3)				
Postgraduate Clinician	8.3% (1)				
Months Providing Supervised Clinical Care in IPC		15.58	9.00	14.94	51 (4-55)
Supervisor-Supervisee Professional Identity Alignment					
Yes	75% (9)				
No	25% (3)				
Model of IPC Practiced					
Primary Care Behavioral Health (PCBH)	83.3% (10)				
Collaborative Care Model (CoCM)	16.7% (2)				
Completed IBH or IPC Coursework					
Yes	75% (9)				
No	25% (3)				
Completed Supervision Coursework					
Yes	58.3% (7)				
No	41.7% (5)				

% (n) – percent (number); M – mean; Mdn – median; SD (standard deviation).
Range (L-H) – range (low to high)

All expert panelists identified as cisgender females (100%), with eight identifying as Caucasian (66.7%), two identifying as Black or African American (16.7%), one identifying as Hispanic or Latina (8.3%), and one identifying as Asian (8.3%). Seven (58.3%) of the expert panelists presented clinical psychology, three (25%) clinical mental health counseling, one (8.3%) clinical social work, and one (8.3%) marriage and family therapy as their professional identities. Expert panelists had a variability in their professional role, with five (41.7%) being current doctoral students, three (25%) being current master's students, three (25%) being current postdoctoral fellows, and one (8.3%) being a postgraduate clinician accumulating hours towards licensure. At the intersection of professional identity and professional standing, four (33.3%) were clinical psychology doctoral students, three (25%) were clinical psychology postdoctoral fellows, one (8.3%) was a clinical mental health counseling master's student, one (8.3%) was a clinical mental health counseling doctoral student, one (8.3%) was a clinical mental health counseling postgraduate clinician accumulating hours towards licensure, one (8.3%) was a marriage and family therapy master's student, and one (8.3%) was a clinical social work master's student.

Expert panelists had a variety of experiences as novice BHCs in IPC settings in clinical and supervisory domains. Expert panelists had a mean of 15.58 and a median of 9.00 months of experience providing direct clinical care to patients in IPC settings with a standard deviation of 14.94, ranging from four months to 55 months. Nine (75%) expert panelists had IPC supervisors who shared their professional identity, while three (25%) did not. Of those whose IPC supervisor did not share their professional identity, a clinical psychologist was the IPC supervisor for a clinical mental health counseling master's student and a marriage and family therapy master's student, and a clinical mental health counselor was the IPC supervisor for a clinical social work

master's student. In their respective IPC setting, 10 (83.3%) expert panelists practiced from a PCBH model, while 2 (16.7%) practiced from a CoCM model.

I gathered data on the educational experiences of expert panelists due to the potential impact of completed IPC and/or supervisory coursework on the perception of supervisory needs for novice BHCs. Nine (75%) of expert panelists completed coursework on IPC or IBH and seven (58.3%) completed coursework on supervision. Four (33.3%) of the expert panelists completed coursework in both IBH or IPC and supervision, three (25%) of which identified clinical psychology as their profession and one (8.3%) identified clinical social work as their profession.

For expert panelists who identified completing coursework associated with IPC or IBH, they indicated the following courses: Health Psychology, Consultation with an Integrated Care Focus, Integrated Primary Care, Collaborative Care, Behavioral Change in Health Counseling, Counseling in Healthcare Settings Integrated Seminar, Integrated Healthcare, Integrated Behavioral Healthcare Seminar, Brief Behavioral Interventions and Treatment, Clinical Practice Integrated Health, Social Work Perspectives in Mental Health Disorders, Behavioral Healthcare, Behavioral Medicine within Healthcare Systems, and Behavioral Health in Primary Care. For expert panelists who identified completed coursework associated with Clinical Supervision, they indicated the following courses: Practicum & Internship, Clinical Supervision, Supervision and Consultation, Supervision Theories/Models, and Advanced Clinical Practice.

Round 1

Data analysis for Round 1 followed open and axial coding procedures (Corbin & Strauss, 2015; Strauss, 1987). At the conclusion of Round 1, 12 expert panelists created 114 initial statements, which were condensed through qualitative analysis into 65 unique, nonredundant

supervisory needs of novice BHCs in IPC settings. These statements were further categorized into nine themes: 1) *The Supervisory Experience* (18 statements); 2) *Supervisor Characteristics* (9 statements); 3) *Supervisor Knowledge & Training* (6 statements); 4) *Interdisciplinary Training* (4 statements); 5) *Medical Training* (9 statements); 6) *Clinic-Specific Orientation*; 7) *Clinical Training*; 8) *Professional Development*; and 9) *Additional Supervisory Needs*.

At the conclusion of Round 1, five initial statements were not included in the list provided to expert panelists in Round 2. Three of these five statements were omitted due to vagueness contributing to researcher challenges identifying the most appropriate context of the statement (i.e., collaborative; systems focused; open) and a lack of clarification after attempts to engage in member checking via email. Two statements were omitted due to inability of needs to be met directly or indirectly through the supervision process and/or supervisor (i.e., physicians that understand the types of patients we can see and how to best use behavioral health providers; supportive clinical staff/team).

Round 2

Data analysis for Round 2 followed both quantitative and qualitative procedures. Twelve out of 12 (100%) of expert panelists who responded to the first round completed Round 2. At the conclusion of quantitative analysis for Round 2, 54 statements generated during Round 1 achieved statistical consensus, whereas 11 did not. Within themes, statement consensus varied. 100% of statements in the *Supervisor Characteristics* (9/9), *Clinic-Specific Orientation* (6/6), *Professional Orientation* (3/3), and *Additional Supervisory Needs* (4/4) themes achieved statistical consensus. Among other themes, 77.78% of statements in *The Supervisory Experience* (14/18), 33.33% of statements in *Supervisor Knowledge & Training* (2/6), 75% of statements in *Interdisciplinary Training* (3/4), 88.89% of statements in *Medical Training* (8/9), and 83.33% of

statements from *Clinical Training* theme (5/6) achieved consensus. In this second round, expert panelists also generated two additional statements that they believed were not adequately represented in the initial list of statements from Round 1. See Appendix F for statistical breakdown of items that did and did not achieve consensus.

Qualitative analysis was conducted for items that did not achieve consensus (i.e., Mdn of ≤2.00 and IQR of ≤1.00) or were added to the list of statements during Round 2 and followed same open and axial coding procedures (Corbin & Strauss, 2015; Strauss, 1987) utilized during Round 1. The 11 statements that did not achieve consensus during the second round were analyzed into 14 distinct statements, created based on feedback provided by expert panelists. Three of the revised statements were placed into different themes when compared to Round 1 due to feedback provided by expert panelists (i.e., one statement moved from *The Supervisory Experience* to *Supervisor Characteristic*, one statement moved from *Supervisor Training & Knowledge* to *Supervisor Characteristic*, one statement from *Supervisor Training & Knowledge* to *Clinic-Specific Orientation*). Two statements that did not achieve consensus had one expert panelist recommend that elimination of the item was most appropriate; these statements were not eliminated due to less than half of participants indicating the appropriateness of elimination. The two statements that were created in addition to the list generated during Round 1 were not assimilated into existing statements that did or did not achieve consensus due to distinctness of ideas. See Appendix F for the statements that did not achieve consensus and associated feedback provided by expert panelists. In total, 16 statements were created after data analysis in Round 2 and were included in the final survey.

Round 3

Data analysis for Round 3 followed quantitative procedures only. All 12 (100%) expert panelists also completed the final survey, indicating retention of every expert panelist across the three rounds of data collection. At the conclusion of Round 3, 14 of the 16 statements created during Round 2 achieved statistical consensus, with two statements not achieving consensus. These two items were not identified as pertinent supervisory needs of novice BHCs in IPC settings. In Round 3, 100% of items in *The Supervisory Experience* (5/5), *Clinic-Specific Orientation* (1/1), *Medical Training* (1/1), *Interdisciplinary Training* (1/1), and *Clinical Training* (1/1) themes reached statistical consensus. Consensus was achieved in 66.6% of statements in the *Supervisory* Characteristics (2/3) and 75% of statements in the *Supervisor Training & Knowledge* (3/4) themes.

Final List of Statements with Statistical Consensus

At the conclusion of Round 3, expert panelists with experience and expertise receiving supervision in IPC settings conceptualized a list of statements as pertinent supervisory needs of novice BHCs in IPC settings. There was a total of 68 statements that achieved statistical consensus spanning nine themes, with two statements not achieving consensus after Round 3. See Table 2 for the list statements and associated statistical indicators.

The Supervisory Experience theme included 19 distinct statements that span behaviors of the supervisor and/or supervisee that enhance the function, relationship, and overall experience of supervision. The *Supervisor Characteristics* theme included 11 statements that expand upon enduring traits and characteristics of supervisors that may contribute to a fruitful supervisory experience; one statement within this theme did not achieve consensus after Round 3. The *Supervisor Knowledge & Training* theme included five statements that identify specialized knowledge and training about clinical practice in IPC settings that expert panelists

Table 2

Supervisory Needs of Novice Behavioral Health Clinicians in Integrated Primary Care

Statement	Mdn	IQR
The Supervisory Experience		
A supervisor that provides constructive feedback (e.g., where the supervisee can improve and/or grow).	1.00	0.00
A supervisor who offers opportunities for Behavioral Health Consultants (BHCs) to shadow the supervisor in their sessions and encounters (e.g., with core BHC and other specialties).	1.00	0.00
A supervisor who provides guidance and mentorship while also allowing enough independence for the training clinician to learn.	1.00	0.00
A supervisor who advocates for the behavioral health team, including the supervisee's needs as a new clinician.	1.00	0.00
A supervisor who dedicates adequate time for contractual supervisory requirements (e.g., 1 hour of supervision per week, individual supervision, group supervision with other integrated care clinicians/grads).	1.00	0.00
A supervisor who is flexible and readily available to provide receptive supervision (e.g., on the fly supervision, allowing for issues outside of direct patient care to come up, support for supervisee with a patient who has risk).	1.00	1.00
Acknowledging the work the Behavioral Health Consultant (BHC) is doing that may be positive and/or good.	1.00	1.00
Allowing space for the Behavioral Health Consultant (BHC) to be critical without taking the criticism as a personal attack.	1.00	1.00
Trust.	1.00	1.00
Open and direct communication.	1.00	1.00
Information about how to practice if the supervisor is out of the office (e.g., go to an Attending Physician if a patient has significant risk or discloses abuse).	1.00	1.00
Egos to be checked at the door.	1.50	1.00
Understanding that supervision is operating from a good and supportive intent.	1.50	1.00
A supervisor who can listen and engage with the supervisee's insecurities (e.g., imposter syndrome).	1.50	1.00
Creating a psychologically safe space for the BHC to receive supervision.*	1.00	0.00
Addressing power dynamics and other 'isms' that could potentially come up in supervision.*	1.00	1.00
A supervisor who provides evaluation and learning opportunities for the Behavioral Health Consultant's (BHC's) professional growth and development.*	1.00	1.00

Statement	Mdn	IQR
A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model, listening to a recorded session) and interactions with other providers a few times throughout training (e.g., once every 3 months, twice a year, few times through the trimester/semester).*	1.50	1.00
Orientation to the supervisee's role in primary care by the supervisor and, if needed, the supervisor making sure there are other staff/clinicians available to do this.*	2.00	1.00
Supervisor Characteristics		
A supervisor who is aware of the potential power dynamics at play and is not afraid to address it.	1.00	0.00
A supervisor who is a team player and emphasizes collaboration.	1.00	0.00
A supervisor who is open to feedback about changes that could enhance the supervision experience.	1.00	1.00
A supervisor who is open and honest about their adaptation to integrated work and the difficulties involved at times.	1.00	1.00
A supervisor who is nonjudgmental.	1.00	1.00
A supervisor who is approachable and personable.	1.00	1.00
A supervisor who is willing to be flexible and able to adjust to supervisees' needs.	1.00	1.00
A supervisor who is willing to teach.	1.00	1.00
A supervisor who values supervision.	1.50	1.00
A supervisor who is open to discussing and encouraging the supervisee's career goals.*	1.00	1.00
A supervisor who is able to open-mindedly understand the values that Behavioral Health Consultants (BHCs) bring and listen to how they are conceptualizing a client.*	1.00	1.00
Supervisor Knowledge & Training		
A supervisor who can fully explain Primary Care Behavioral Health (PCBH).	1.00	1.00
A supervisor with broad expertise and generalist knowledge.	1.00	1.00
A supervisor who has experience working in integrated settings.**	1.00	1.00
A supervisor with an understanding of modalities common in primary care (e.g., Motivational Interviewing).**	1.00	1.00
A supervisor who has a strong understanding of the biopsychosocial model and models used by other healthcare team members (e.g., biomedical model, integrated and collaborative models).*	2.00	1.00
Interdisciplinary Training		
Information about if and/or how to educate medical providers on behavioral health concepts.	1.00	0.00
Mentorship about building relationships with other disciplines behavioral health clinicians work with.	1.00	1.00
Information about how to integrate and collaborate with interdisciplinary teams and medical providers of multiple specialties.	1.00	1.00

Statement	Mdn	IQR
Formal (e.g., monthly meeting) and informal (e.g., communicate via Electronic Medical Record) collaboration with physicians to discuss certain patients that are struggling.*	2.00	1.00
Medical Training		
Information about somatic symptoms related to behavioral health concerns.	1.00	1.00
Information about who to seek if a patient needs psychiatric consultation.	1.00	1.00
Information and trainings about common health conditions (e.g., chronic pain, insomnia) and medications that are intertwined with and affect mental health.	1.00	1.00
A basic understanding of differing roles and/or programs when coming into integrated care settings.	1.00	1.00
Information about Primary Care and/or Family Medicine practices.	1.50	1.00
Information and ongoing discussion about medical knowledge and terminology, physical health, medical issues, and common medical conditions.	2.00	1.00
Information about primary care culture.	2.00	1.00
Information about the medical model.	2.00	1.00
An understanding of medications within the scope of the Behavioral Health Consultant (BHC), including common medications prescribed at the site.*	2.00	1.00
Clinic-Specific Orientation		
Information and knowledge about clinic procedures, logistical flow (e.g., other disciplines flow), and how behavioral health integration fits into the clinic (e.g., role of the Behavioral Health Consultant).	1.00	1.00
Information and understanding about the patient population being served.	1.00	1.00
Information about the Electronic Health Record system.	1.00	1.00
Information and guidance on how to offer behavioral health consultations and services (e.g., warm handoffs, during vs. separate from medical appointment) and where to meet with patients (e.g., exam rooms, separate offices).	1.00	1.00
A supervisor who offers opportunities to learn about integrated care practices.	1.00	1.00
Information about specific clinic culture and dynamics.	2.00	1.00
A supervisor who can fully explain warm handoffs within the clinic (e.g., how they function in the clinic, how to approach them clinically).*	1.50	1.00
Clinical Training		
Differentiation between typical therapy practices and behavioral health consultant work.	1.00	1.00
Training and room to develop relevant skills, such as writing factual and concise documentation (e.g., session notes) and therapy techniques.	1.00	1.00

Statement	Mdn	IQR
A supervisor who offers trainings and opportunities to learn and apply evidence-based treatments that are common in primary care settings, such as Cognitive Behavior Therapy (CBT; e.g., CBT for Chronic Pain, CBT for Insomnia), Motivational Interviewing (MI), and Acceptance & Commitment Therapy (ACT).	1.00	1.00
Being well-versed in risk assessment.	1.00	1.00
Information about how to meet the patient where they are with their symptoms and presentations, and how to interact with them (e.g., how to introduce self, engage patients).	2.00	1.00
Training on the treatment of loss and grief (e.g., when to refer to outpatient).*	2.00	1.00
Professional Development		
Provision of opportunities for career and professional advancement (e.g., career advancement opportunities outside of licensure, critiques for growth).	1.00	1.00
A supervisor who helps guide the Behavioral Health Consultant (BHC) towards professional growth and development.	1.00	1.00
Information about professional development opportunities.	2.00	1.00
Additional Supervisory Needs		
Multicultural competency and sensitivity.	1.00	0.00
Ongoing support from supervisors to supervise.	1.00	1.00
Ethical training.	1.50	1.00
Community resources.	1.50	1.00
Items That Did Not Achieve Consensus		
Supervisor Characteristics		
A supervisor who is willing to research with the supervisee.	3.00	1.00
Supervisor Training & Knowledge		
A supervisor who can conceptualize eclectically and/or connect to resources for conceptualization.	2.00	2.00

Mdn – median; IQR – interquartile range
** - achieved consensus during Round 3*

conceptualized as imperative for clinical supervisors to possess; one statement within this theme did not achieve consensus after Round 3. The *Interdisciplinary Training* theme included four statements that identify training that novice BHCs would benefit from receiving during supervision related to interdisciplinary communication, collaboration, and practice commonplace in IPC settings. The *Medical Training* theme included nine statements that identify training that novice BHCs would benefit from receiving during supervision related to basic medical dimensions of behavioral health practice in IPC settings. The *Clinic-Specific Orientation* theme

included seven statements related to information related to the conceptualization and expectations of behavioral health services within the IPC clinic that will be important for effective integration into the site. The *Clinical Training* theme included six statements related to specific clinical training provided by the supervisor that may enhance the novice BHCs' ability to effectively provide behavioral health services within an IPC setting. The *Professional Development* theme included three statements related to ongoing professional growth and development that novice BHCs may benefit from receiving from supervision. Finally, the *Additional Supervisory Needs* theme included four items that were not thematically like other statements yet were conceptualized as vital supervisory needs of novice BHCs in IPC settings.

Chapter Summary

In this study, 12 expert panelists with experience as behavioral health supervisees in IPC settings completed three rounds of anonymous surveys and achieved statistical consensus across on 68 distinct, nonredundant statements that they conceptualized as pertinent supervisory needs of novice BHCs in IPC settings. These statements were categorized into nine themes, spanning *The Supervisory Experience*, *Supervisor Characteristics*, *Supervisor Knowledge & Training*, *Interdisciplinary Training*, *Medical Training*, *Clinic-Specific Orientation*, *Clinical Training*, *Professional Development*, and *Additional Supervisory Needs*.

CHAPTER FIVE

DISCUSSION

In this chapter, I will explore the results of this study within the context of current IPC and supervision literature. First, I will briefly explore the context of the study and the sample of expert panelists who generated and agreed upon the statements of novice BHP needs in IPC settings. Then, I will connect the findings from this study with established literature related to IPC practice, supervision, and training. Afterwards, I will provide an exploration of the implications of this research for behavioral health SORs and educators, novice BHPs, and the field of IPC. Finally, I will provide future directions for research and review the pertinent limitations of the study.

Context for the Study and Its Sample

In this study, 12 expert panelists identified 68 statements related to the pertinent supervisory needs of novice BHPs in IPC settings. This study is uniquely placed in the context of other literature on IPC supervision in that behavioral health SEEs from various professional identities (i.e., clinical mental health counseling, clinical psychology, clinical social work, marriage and family therapy) were conceptualized as subject matter experts due to their positionality as the direct recipients of IPC supervision. Additionally, this study was conducted through a dual post-positivist and social constructivist framework that places the findings as subjective perspectives and experiences of the expert panelists made objective through statistical analyses. This provides a perspective that promotes lived truths of the expert panelists while acknowledging that truth itself is inherently subjective, allowing for individuals to interpret the findings within the confines of their own experiences and as the truth of a group of experts in the supervisory needs of novice BHPs in IPC settings. Therefore, this study adds to the literature by

bringing an objective dimension to the subjective experiences and perceptions of novice BHPs in IPC settings, expanding upon prior research on BHPs' perceptions of supervision in these spaces and creating specificity on a wide range of supervisory needs of trainees in IPC.

Due to the importance of the expert panel in Delphi methodologies, a brief discussion on demographics of the expert panelists is an important component to explore. Most expert panelists in the current study identified as White females who were working towards a doctoral degree in clinical psychology, which aligns with current IPC and IBH workforce trends (Collaborative Family Healthcare Association, 2023). Additionally, most expert panelists indicated sharing a professional identity with their SOR and practicing through the PCBH model of care. On the other hand, 75% of expert panelists indicated the completion of specialized coursework in IBH or IPC, which differs from prior literature in which researchers identified a shortage of providers who are trained in IPC (Blount & Miller, 2009; Hall et al., Ma et al., 2022). This may be due to the recruitment and sampling methods, as I intentionally recruited individuals from academic, professional, and clinical organizations that have a history of IPC initiatives (e.g., Health Resources and Services Administration – Behavioral Health Workforce Education and Training Grants, Clinical Health Psychology concentration, established PCBH programs). Therefore, the academic experiences of expert panelists in this study may not likely be representative of other novice BHPs in IPC settings, as IPC training opportunities in graduate behavioral health education programs remain sparse (Mullin & Funderburk, 2013).

Theme 1: The Supervisory Experience

The first and largest theme of statements identified by expert panelists was *The Supervisory Experience*, which highlights critical SOR and/or SEE behaviors that serve to enhance the relationship, function, and overall experience of supervision in IPC settings. The

expert panelists largely identified the importance of formative, normative, and restorative functions that may be present across all clinical supervision experiences (Bernard & Goodyear, 2019) and are reflected in SOR clinical supervision skills for IPC settings (Ogbeide & Bayles, 2023). In the results of this study, this is seen in statements that highlight the SOR's provision of feedback on a variety of topics, evaluation on professional growth, the provision guidance and mentorship, and responsiveness to personal concerns that may be affecting clinical practice. Additionally, expert panelists indicated foundational components of trust and effective communication, the perspective of supervision as supportive and meant for growth purposes, and the bidirectional role of feedback between SOR and SEE as a necessity for supervision in IPC. Trust, ongoing communication, addressing the intersection of cultural identities and experiences, and responding to potential resistance are all vital components of an effective supervisory relationship (Bernard & Goodyear, 2019; Corey et al., 2021), and were identified by expert panelists as important dimensions of the supervisory experience. These dimensions, particularly trust, have been identified as important for supervision in IBH settings (Kracen et al., 2023), with some individuals indicating the relational component of supervision being missing (Li et al., 2022).

Moving past some of the foundational components of the supervisory experience that may transcend the context, expert panelists also identified various context-specific dimensions of this theme. Expert panelists highlighted the importance of having an orientation facilitated by the SOR that focuses on the role of the BHP, with the addition of having other primary care staff to supplement the orientation. This may look like an office manager orienting the novice BHP to the business practices of the clinic, a billing specialist orienting the novice BHP to ways in which they can bill for same day versus scheduled behavioral health visits, and/or a technological

liaison to assist in orienting the novice BHP to the electronic medical record, among others. The need for this orientation to the roles of BHPs in primary care aligns with research highlighting a challenge for BHPs transitioning into IPC settings being role uncertainty and confusion (Cox et al., 2014; Berkel et al., 2019; Li et al., 2022) and current practices for IPC training (Ma et al., 2022). Expert panelists perceived having an orientation to the role of the BHP in IPC as a vital supervision task.

Additionally, the importance of supervision time and availability was highlighted, as primary care tends to be fast paced, evidenced by the Accessible and Highly Productive domains of IPC conceptualizations (Reiter et al., 2018). In prior studies, researchers have indicated that SEEs may perceive their SOR as unavailable for consistent or as-needed supervision (Kracen et al., 2023; Li et al., 2022), which aligns with challenges related to various roles expected of SORs in IPC settings while remaining adherent to the pace of primary care (Ogbeide et al., 2024). It is unsurprising that expert panelists highlighted the importance of having a SOR who structures and prioritizes time for formal supervision hours while remaining accessible for supervision that is requested on an 'as-needed' basis. This may allow SEEs to feel supported in the supervisory relationship, as consistency in supervision and the availability of support when needed most (e.g., a patient experiencing risk) may provide stability in a new, potentially stressful professional environment.

Observation was another important dimension of supervisory needs of novice BHPs in IPC settings, oriented towards both SOR and SEE. Regarding the SEE, panelists indicated the importance of novice BHPs observing their SOR's clinical and professional interactions with patients, other providers (e.g., other BHPs, PCPs, other medical staff), and other staff in the clinic via shadowing. Prior researchers have found that trainees perceived shadowing as a

meaningful experience for professional development in IBH settings (Li et al., 2022), with this being a routine part of some clinics' onboarding process (Ma et al., 2022). Despite this, other researchers have indicated that future supervision in IBH settings would benefit from additional shadowing opportunities for new BHPs professional development (Kracen et al., 2023). Regarding the SOR, the expert panelists also indicated the importance that the SOR observes the SEE's interactions with patients and providers at various times throughout, either face-to-face or via recordings. Direct observation of the SEE's work is an important dimension of supervision; the PARSE model proposed by Mancini et al. (2019) may provide the ideal scenario for observation of the SEE's clinical work while matching the context of IPC. These two statements align with a scaffolding approach recommended for supervision in IPC, in which SEEs start by shadowing the SOR, moving to co-visits with the SOR and SEE, ending with the SOR shadowing the SEE's independent visits (Ogbeide et al., 2024). From the expert panelists' perspective, observation of the SOR by the SEE, and vice versa, are important needs of novice BHPs in IPC settings to promote professional growth as an IPC clinician.

Finally, expert panelists indicated the need for supervisory experiences that are related to the context of the BHP in the primary care setting. It was identified that a SOR who advocates for the behavioral health team is important for supervision, as this may enhance new BHPs' sense of belongingness in the primary care setting and further promote a sense of interprofessional connectedness between disciplines in IPC settings. Additionally, expert panelists indicated the importance of SORs providing practical suggestions and expectations related to how to serve as a BHP when the SOR is not available, including who to inform in case of a more urgent clinical event (e.g., patient suicide risk). These appear to be important in the pursuit of having the novice BHP feeling connected as a part of an interdisciplinary IPC team, as

ongoing advocacy from the SOR for the behavioral health team and information on how they can best provide care in the absence of the SOR may enhance their ability to practice in IPC settings. This may also contribute to more thorough levels of integration for novice BHPs, enhance care to patients, and better interprofessional collaboration and understanding.

Theme 2: Supervisor Characteristics

The second theme identified was the *Supervisor Characteristics* theme, which includes 11 statements that expand upon enduring traits and characteristics of SORs that may contribute to a fruitful supervisory experience. We conceptualized this theme as interconnected with the other themes, as enduring SOR characteristics may contribute to more effective supervisory relationships and interventions in IPC settings. Expert panelists indicated the importance of SORs who exhibit patterns of openness to the wide range of experiences that SEEs may bring to supervision, exploring SEE career goals, feedback from the SEE, and sharing their own experiences as a BHP in IPC settings. This openness, when paired with other SOR characteristics identified by expert panelists – being nonjudgmental, approachable, flexible, and cognizant of cultural and power dynamics – may be instrumental SOR factors in the development of a fruitful supervisory relationship and experience (Bernard & Goodyear, 2019; Borders, 2014; Borders et al., 2014; Corey et al., 2021). This may be particularly important for supervision in IPC settings, as SEEs provide care in a context that may be perceived as daunting and complex due to the necessary biopsychosocial emphasis and interprofessional orientation.

Related to this openness, expert panelists also indicated the importance of having a SOR who is open about their experiences in integrated care settings, particularly the adaptation to a new setting and the associated challenges. This aligns with findings of SORs' intentionality in sharing their own IBH clinical experiences in supervision (Giresunlu et al., 2024) and may be

particularly instrumental in normalizing SEEs' difficulties that are commonplace when BHPs transition into IBH settings (Berkel et al., 2019; Cox et al., 2014; Dice et al., 2022; Glueck, 2015; Li et al., 2022; Prom et al., 2021). Given that prior BHPs in IBH settings have indicated experiencing SORs who have not effectively attended to the therapeutic and interpersonal components inherent in supervision (Kracen et al., 2023; Li et al., 2022), these characteristics may be imperative for new BHPs to get the most out of their supervision. Expert panelists in this study identified needing a SOR who exemplifies many of the personal factors and characteristics that assist in facilitating the supervisory experience, potentially allowing SEEs to get the most out of supervision.

Expert panelists also agreed that novice BHPs in IPC would benefit from having a SOR who values supervision as an experience. Supervision is conceptualized as the "signature pedagogy" of behavioral health professions (Bernard & Goodyear, 2019, p. 2). Ogbeide et al. (2023) reinforces the reality that supervision is a vital training experience in IPC settings to ensure BHP development and quality patient care. Similarly, Borders et al. (2014) indicate the importance of having a SOR who can clearly conceptualize the process of supervision, including all the roles and responsibilities associated with being a SOR. One of the most important roles for the IPC SOR may include being a teacher, a crucial dimension of the Discrimination Model (Bernard, 1979). Due to the limited availability of formal training in IPC during graduate programs (Mullin & Funderburk, 2013), teaching through modeling and other formats (e.g., consultation) has repeatedly been identified as a crucial skill and role for IPC SORs in the literature (Giresunlu et al., 2024; Ogbeide & Bayles, 2023; Ogbeide et al., 2023a; Ogbeide et al., 2024). A supervisor who values the function, relationship, and benefits of supervision may be a

vital component of clinical supervision for many new BHPs in IPC settings, as it may normalize the process of supervision and reinforce the importance of supervision during clinical training.

Theme 3: Supervisor Knowledge & Training

The third theme identified by expert panelists is *Supervisor Knowledge & Training*, which expand upon five statements related to the knowledge and training SORs would benefit from having when providing novice BHPs with supervision in IPC settings. SOR training has been identified as a vital component of effective supervision, with this being an important dimension of the *Supervision Best Practices Guidelines* created by Borders et al. (2011). This is no different for IPC supervision, with researchers indicating the importance of SORs receiving training for how to effectively provide supervision in these settings (Ogbeide et al., 2024) and identifying supervisor competencies for IPC (Ogbeide & Bayles, 2023). Therefore, it is expected that the expert panelists identified the need for SORs to have specific knowledge and training. In alignment with conceptualizations of BHPs practicing as *Generalists* in IPC settings (Reiter et al., 2018), expert panelists indicated the importance for SORs to have broad expertise and knowledge practicing as a generalist. Additionally, expert panelists wanted SORs to have knowledge of the PCBH model and the ability to apply this through teaching efforts; this is an interesting result, as two expert panelists indicated practicing through a CoCM model. Regardless, each of these align with established competencies for IPC supervision (Ogbeide & Bayles, 2023). Therefore, SORs would benefit from an ability to be a generalist and fully explain the model of IPC that is being utilized in the IPC setting, which expert panelists in this study identified as the PCBH model.

Importantly, expert panelists indicated new BHPs would need a SOR who has professional experience in integrated care settings, such as IPC. Given the context of IPC is one

that significantly deviates from the context of specialty mental health settings, expert panelists highlighted the importance of having a supervisor who has experience in IPC. While supervision training has been identified as an important component of supervision best practices (Borders et al., 2014), researchers have identified that formal IPC supervision training may be sparse (Ogbeide et al., 2024). Therefore, SORs possessing professional experience as a BHP in an IPC setting may set an important foundation for the provision of effective supervision and be conceptualized as a need for new BHPs in IPC (Hall et al., 2015). This experience relates to the other items in *Supervisor Knowledge & Training*, understanding of behavioral health treatment approaches in IPC and models of care used by IPC teams (i.e., biopsychosocial model, biomedical model). An understanding of and ability to consider biopsychosocial and biomedical models of care in the culture of IPC has been identified as an imperative for IPC SORs (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023). Additionally, ability to conceptualize and understand behavioral health treatment approaches may assist in facilitating formative development in SEEs (Bernard & Goodyear, 2019) while ensuring quality patient care. Ogbeide et al. (2024) identified enhancing conceptualization, assessment, and intervention as a common goal of IPC supervision, further reinforcing the importance of SORs' ability to understand treatment perspectives for IPC.

Theme 4: Interdisciplinary Training

The *Interdisciplinary Training* theme included four statements that expert panelists identified as important training for novice BHPs in IPC settings to receive during supervision. Interprofessional collaboration is an integral component of IPC, represented in competencies for clinical practice in integrated care and IPC settings (Hoge et al., 2014; McDaniel et al., 2014; Robinson & Reiter, 2016; Sockalingam et al., 2020). Due to the inherently interprofessional

nature of IPC, expert panelists identified various interdisciplinary topics new BHPs would need training in during IPC supervision. This aligns with prior findings where researchers identified interdisciplinary topics and collaboration as commonplace during IBH supervision (Giresunlu et al., 2024; Ogbeide et al., 2024). BHPs in IPC settings are often conceptualized as 'educative,' providing formal and information education through a variety of avenues (e.g., psychoeducation intervention, curbside consultation, handouts) to patients, communities, and providers (Reiter et al., 2018). Therefore, expert panelists conceptualized a pertinent need for novice BHPs in IPC settings is to receive information about the instances in which providing education to medical providers is warranted, as well as how they can do this effectively. By having a more thorough understanding of when and how to educate medical staff, BHPs may feel more connected as part of an interprofessional team and be able to contribute to more comprehensive patient care, even when they do not directly see that patient.

Expert panelists also indicated the importance of mentorship on building relationships in IPC settings and maintaining the interdisciplinary component of IPC through purposeful integration, collaboration, and communication with interdisciplinary team members. Prior researchers have indicated an important IPC SOR competency is the ability to engage in ongoing interprofessional communication (Ogbeide & Bayles, 2023). Additionally, novice BHPs have indicated challenges associated with building interprofessional relationships and engaging in effective interprofessional communication in the IPC setting (Cox et al., 2014; Dice et al., 2022; Prom et al., 2021). Use of supervision to explore IPEC competencies for interprofessional collaboration (IPEC, 2013) and associated strategies may be an effective strategy in the pursuit of building interprofessional relationships and promoting ongoing collaboration. Orienting the SEE towards the different ways in which novice BHPs can engage in ongoing communication

(e.g., monthly provider meetings, messages in the Electronic Medical Record, curbside consultation) may be an important dimension that IPC SORs would benefit from addressing, as creating interprofessional relationships without ongoing strategies for collaboration and communication may not promote a comprehensive, biopsychosocial care orientation that underlies the IPC movement (Peek & Council, 2013).

Theme 5: Medical Training

The *Medical Training* theme included nine statements that expert panelists believed encapsulate medical knowledge and training that novice BHPs would benefit from receiving during supervision. Due to the context of and patient populations in IPC settings, BHPs are often responsible for providing behavioral health interventions for traditional mental health concerns and for medical concerns (Serrano et al., 2018). Therefore, expert panelists indicated the need for novice BHPs to receive specialized training related to medical dimensions of the BHP's role. This importance is highlighted by prior researchers, as BHPs in IBH and IPC settings have indicated a lack of training and knowledge on basic medical concepts and topics (Glueck, 2015; Li et al., 2022). Expert panelists identified the reception of information about somatic symptoms, medical concerns, medical terminology, and medications, particularly as they relate to behavioral health concerns and practice. This aligns with current literature outlining the prevalence behavioral health concerns associated with medical conditions (Burg & Oyama, 2016) and competencies for BHPs in IBH settings (Hoge et al., 2014; McDaniel et al., 2014; Robinson & Reiter, 2016; Sockalingam et al., 2020). Additionally, researchers have identified the importance that SORs in IPC settings understand behavioral health practice, basic medical terminology, and behavioral medicine oriented to the primary care context (Ogbeide & Bayles, 2023) and explore these topics during supervision (Edwards & Patterson, 2006). This indicates the importance that

SORs review basic medical information as it relates to BHP practice in IPC, spanning medical health, medical illnesses, medication, and physical manifestations of behavioral health concerns.

Outside of medical information related to clinical domains of BHP practice in IPC settings, expert panelists also indicated training necessary for understanding the medical system and environment. Edwards and Patterson (2006) have indicated the importance of understanding the context of the SEE in the health system and clinic, while Ogbeide and Bayles (2023) identified the vital nature of SORs in IPC settings understanding primary care from a systemic and contextual perspective. Expert panelists indicated the importance of receiving information on primary care culture, the medical model, common practices of IPC settings and medicine disciplines (i.e., Family Medicine), and roles and programs of IPC programs. This information promotes a better understanding of the medical providers they work alongside and the overarching context in which they provide behavioral health services, allowing for greater interprofessional collaboration and more effective clinical services from novice BHPs.

Expert panelists also highlighted the importance of receiving information on who to seek if a patient needs psychiatric consultation. For novice BHPs working through the CoCM approach, this may mean communicating with the consulting psychiatrist for intentional medication management and/or psychiatric assessment. For other models, such as PCBH, this may translate to communicating with medical colleagues with training in psychiatric concerns and/or seeking a referral to a psychiatric provider. Regardless of the model of IPC, the ability to recognize and allocate referrals for care coordination, such as psychiatric consultation, is an important competency for BHPs in IPC settings (Hoge et al., 2014; Robinson & Reiter, 2016). Therefore, expert panelists indicated the importance of novice BHPs understanding who to seek

when patients may require psychiatric consultation for a more acute, urgent, or specialized mental health concern.

Theme 6: Clinic-Specific Orientation

The *Clinic-Specific Orientation* theme included seven statements that identified information related to administrative, logistical, and clinical dimensions of clinical practice that BHPs would need to know to work effectively in their specific clinic. In this theme, expert panelists indicated components of ongoing orientation to the clinic that would enhance novice BHPs' ability to effectively integrate into the site. Elements such as the clinic dynamic and culture and patient populations served were highlighted, as each of these components may significantly affect the ways in which BHPs practice in IPC settings. Clinic culture is an important consideration for supervision, as the culture of leadership and other clinicians may significantly affect clinical and interprofessional practices, philosophical orientations to healthcare, the model of integration, and the level of integration that BHPs may experience in IPC (Gass et al., 2023; Giresunlu et al., 2024; Heath et al., 2013; Ramanuj et al., 2019). These practices and policies may also differ depending on the patient population being served in the clinic. While primary care is associated with care for individuals at any stage of life or presenting concerns (Jimenez et al., 2021), there may be significant clinical, ethical, and legal considerations for IPC clinics and BHPs that serve a specific population (e.g., pediatric, LGBTQ, rural, lower income; Moe et al., 2018; O'Loughlin et al., 2019; Scafe et al., 2021). Therefore, a comprehensive understanding of the specific culture and patient population of the clinic is an imperative need of novice BHPs in IPC settings to be addressed in supervision.

Robinson and Reiter (2016) outline administrative skills that are vital for competence in IPC settings from a PCBH perspective, including an understanding of policies and procedures of

behavioral health services, which may encapsulate the initiation and provision of behavioral health services. Expert panelists indicated the importance of being oriented to the ways in which behavioral health integration fits into the clinic, including the clinical and logistical details of providing behavioral health care. Warm handoffs were specifically mentioned, indicating the benefit of providing information about the function of these practices in the specific IPC setting to novice BHPs. On a larger scale, expert panelists indicated needing an opportunity to learn about integrated care practices, which may include administrative, logistical, financial, and clinical practices that are present in the current clinic and in other integrated settings. This may contribute to a more cohesive understanding of behavioral health integration in medical settings and IPC, potentially allowing the novice BHP to contribute to the clinic more meaningfully.

Finally, expert panelists indicated the need for novice BHPs to receive information about the Electronic Health Record (EHR) that the IPC clinic utilizes. The EHR is an important technological instrument in the provision of behavioral health in IPC settings, as it allows for collaboration with interdisciplinary primary care team members, secure communication with patients, documentation of patient clinical interactions and care plans, and identification of patients who would benefit from the range of services offered by BHPs (Robinson & Reiter, 2016; Zerden et al., 2021). Despite this, many EHRs may be complex and contribute to challenges in effectively completing and documenting clinical tasks (Mishuris & Linder, 2012), especially for new clinicians. Novice BHPs in IPC settings need to be oriented to the EHR used by the clinic to ensure documentation, communication, and utilization of other features is utilized at the highest level. This aligns with prior research on the importance of IPC SORs to understand use of technology in primary care and the resources available to BHPs in the EHR (Ogbeide & Bayles, 2023).

Theme 7: Clinical Training

The *Clinical Training* theme included six statements that identified training provided to the novice BHP by the SOR related to effective clinical practice in IPC settings. Serrano et al. (2018) have indicated the need for many novice BHPs to be retrained clinically and conceptually when transitioning into IPC settings due to the focus on specialty mental health in graduate training programs. Therefore, expert panelists indicated the importance of novice BHPs receiving information about the differences between traditional therapy and the practice of BHPs in IPC settings. Prior researchers have indicated significant differences between the philosophical and clinical approaches of BHPs in specialty mental health versus IPC settings (Hall et al., 2015; Robinson & Reiter, 2016). Additionally, it has been identified that new BHPs in IBH settings often struggle to adapt to the clinical practice expectations, namely the pace of the setting and providing targeted behavioral health services (Berkel et al., 2019; Cox et al., 2014; Glueck, 2015; Li et al., 2022). Therefore, SOR-initiated training on how novice BHPs can adapt their style of practice to match to IPC context will be an important task to ensure that BHPs have the necessary skills.

Related to this, expert panelists highlighted the need for novice BHPs in IPC settings to receive ongoing training and application opportunities focused on relevant documentation and therapeutic interventions, particularly in empirically supported treatments that fit the IPC context. Regarding empirically supported treatment approaches, expert panelists specifically highlighted Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Motivational Interviewing (MI) and their application to behavioral health and behavioral medicine contexts. These treatment approaches have been indicated as appropriate for IPC settings and used by BHPs in IPC settings (Bridges et al., 2015; DiTomasso et al., 2009;

Funderburk et al., 2018; Strosahl et al., 2012). Related to theory-driven treatments, expert panelists highlighted the importance of facilitating the growth of other therapeutic techniques for practice in IPC, which may include contextual interviewing (Cahill et al., 2024), psychoeducation, behavioral goal setting, and other transdiagnostic skills. These may serve as an important foundation for assessing, supplementing, and following up with theory-driven interventions. Related to clinical skills, the importance of training on documentation was highlighted, with this skill being an important clinical, ethical, and legal component of all behavioral health services (AAMFT, 2015; ACA, 2014; APA, 2017; NASW, 2021), including those situated in IPC settings (Robinson & Reiter, 2016; Hoge et al., 2014; McDaniel et al., 2014; Zerden et al., 2021). Prior researchers have indicated SOR ability to review and provide corrective feedback to ensure context-congruent documentation is a crucial component of IPC supervision (Ogbeide & Bayles, 2023). In this study, expert panelists indicated the importance of novice BHPs receiving training on empirically supported treatment approaches, additional therapeutic techniques, and documentation skills to ensure competent clinical practice.

Under the *Clinical Training* theme, the final supervision needs the expert panelists identified as imperative for novice BHPs in IPC settings spanned risk assessment and the treatment of loss and grief in the primary care context. Risk assessment may be a particularly important topic to review in IPC supervision due to the prevalence of suicide-related concerns in primary care; researchers have identified that of those who have completed a suicide attempt, 77% and 45% had primary care contact in the year and month leading to their death, respectively (Luoma et al., 2002). The verbiage agreed upon by expert panelists indicate the need for a foundation in risk assessment skills, yet these skills can be enhanced and built upon by supervision experiences that focus on risk assessment in the primary care context. While this

topic was identified as important for SORs in IBH settings to review in one study (Giresunlu et al., 2024), suicide and risk assessment is largely missing from the IPC supervision literature. Despite this, guidelines exist for clinicians in IPC settings for managing suicidality in a primary care congruent manner (Bryan et al., 2009) and could help to structure supervision experiences related to risk assessment. Closely related to the topic of risk in primary care may be grief and loss; expert panelists interestingly highlighted the need for information on the treatment of grief and loss in primary care. Due to the comprehensiveness of primary care (Jimenez et al., 2021), it is likely that IPC teams will encounter individuals experiencing grief and loss in some capacity, whether traditional (e.g., death of an important individual) or nontraditional (e.g., loss of independence due to chronic illness). Due to this, the importance of exploring grief, loss, and risk assessment in the primary care context during supervision cannot be understated, as novice BHPs may struggle to adapt to the context of primary care while maintaining fidelity to the ethical, legal, and clinical considerations that accompany these concerns.

Theme 8: Professional Development

The *Professional Development* theme included three statements that outlined novice BHPs' supervisory needs related to ongoing professional growth in the IPC context. Expert panelists indicated the importance that novice BHPs receive information, guidance, and opportunities to enhance their professional development. This has been identified as an unmet need in supervision among certain BHPs (Kracen et al., 2023). Professional development is conceptualized as "gaining new skills through continuing education and career training after entering the workforce. It can include taking classes or workshops, attending professional or industry conferences, or earning a certificate…" (Parsons, 2022). Giresunlu et al. (2024) indicate the importance of creating environments and opportunities for professional development of

trainees in IBH settings. This may be especially pertinent for new BHPs, as the current behavioral health workforce for IPC settings may not be sufficient (Hall et al., 2015) and encouragement towards ongoing professional development may be an important factor in building the workforce needed for adequate BHP staff in IPC settings. Information and opportunities such as these may enhance professional capacity and confidence to perform the wide range of roles asked of BHPs in IPC settings (e.g., clinician, program administrator, researcher; Glueck, 2015) while promoting connectedness with BHPs and other providers in in different IPC systems through conferences, workshops, and other networking opportunities.

Theme 9: Additional Supervisory Needs

The final theme, *Additional Supervisory Needs*, included four statements on novice BHPs' supervisory needs that were conceptualized as important yet did not thematically match other items. Expert panelists indicated the importance of supervision to enhance multicultural competency and sensitivity, as well as ethical practice in IPC. The intentional exploration and integration of ethical and cultural considerations in treatment is a common dimension of IPC supervision literature (Giresunlu et al., 2024; Kracen et al., 2023; Ogbeide et al., 2024). Researchers have indicated awareness of ethical considerations in IPC and integration of cultural sensitivity in clinical work are important competencies for BHPs in IBH settings (Hoge et al., 2014; McDaniel et al., 2014; Robinson & Reiter, 2016; Sockalingam et al., 2021). While foundational principles for ethical and culturally sensitive clinical practice in IPC remains prevalent, there are unique ethical (e.g., informed consent, confidentiality, multiple relationships; Kanzler et al., 2013; Runyan et al., 2018) and multicultural (e.g., social determinants of health, health disparities; O'Loughlin et al., 2019; Yearby, 2022) considerations to clinical practice in IPC settings. An understanding of these ethical and cultural practices and considerations has

been identified as an important dimension of IPC SOR competence (Ogbeide & Bayles, 2023). Therefore, ample attention in supervision on cultural competence and sensitivity, paired with exploration of ethical dilemmas and problem solving for IPC, is an importance supervisory need for novice BHPs in IPC settings.

Expert panelists also indicated the importance of novice BHPs understanding community resources that are available to the patient population. Due to the impact of social determinants of health and other socially located concerns, novice BHPs in IPC settings would benefit from knowing what resources are available to their patients, as well as how to communicate with, access, and guide patients towards these resources. Knowledge and ability to apply community resources to patient treatment has been identified as an important skill that may supplement the comprehensive care provided by IPC teams (Robinson & Reiter, 2016). While researchers have identified a lack of available community resources for patients as a challenge to behavioral health integration in primary care (Blasi et al., 2018), other researchers have identified that BHPs in IPC settings may provide an important bridge to the resources that are available (Cooper et al., 2022). Therefore, ongoing discussion about community resource identification and referral was identified as a pertinent need for novice BHPs in IPC settings.

The final statement that was identified as a supervisory need of novice BHPs in IPC settings relates to ongoing support for SEEs to supervise from current IPC SORs. Currently, there is a dearth of specialized training available for SORs in IPC settings (Ogbeide et al., 2023a; Ogbeide et al., 2024) and BHPs have indicated missing the development of future supervision skills during current supervision experiences as SEEs (Kracen et al., 2023). Therefore, experiences as a SEE in IPC settings may be an important experience in which future IPC SORs can learn from to enhance their own supervisory practice. SORs who encourage their SEEs to

supervise in the future may also allow for more novice BHPs to be trained, as advanced doctoral students or graduates in the behavioral health professions can supervise clinicians with less experience under the supervision of a more experienced IPC SOR. Supervision of supervision has been conceptualized as an appropriate strategy for training and developing IPC SORs (Ogbeide et al., 2024) and may be an important dimension to enhancing the development of the behavioral health workforce in IPC.

Items that Did Not Receive Consensus

There were two items that expert panelists did not achieve consensus on, indicating that these items may be important for some SEEs in IPC settings, yet may not be an imperative supervisory need for novice BHPs. While quality improvement and research has been identified as an important component of IPC (Robinson & Reiter, 2016), expert panelists did not see collaborative research as a supervision imperative for novice BHPs in IPC settings. While research may be an imperative during certain training experiences and among specific SEEs, it is not a necessity for most novice BHPs. Additionally, expert panelists did not agree that SOR eclectic conceptual abilities was important, potentially indicating that novice BHPs are open to the conceptual inclinations of their SORs if their other needs are being met.

Implications

The results of this study provide insight into the foundational supervisory needs of novice BHPs in IPC settings. In turn, this may provide insight into the ways in which SEEs can be better prepared to fully integrate into and provide behavioral health services in IPC settings. The data from this study has implications for various individuals associated with IPC settings across behavioral health professions, including supervisors, novice behavioral health clinicians, and educators.

Implications for Supervisors

The results from this study have the most implications for SORs who are currently providing supervision to individuals who are collecting clinical hours in IPC settings. The statements created and agreed upon by expert panelists provide SORs insight into the needs of novice BHPs when transitioning into clinical roles in IPC settings. This may be especially true for SORs that are at IPC sites with their SEEs. SORs in IPC settings with novice BHPs will likely be the main point of contact, support, and direct training for novice BHPs. Therefore, active efforts to integrate the needs identified in this study into supervisory experiences may become an important dimension of clinical training experiences in IPC settings.

Notably, this data provides SORs in IPC settings with a format for structuring, delivering, and evaluating clinical supervision. The literature base for supervision in IPC is growing, with researchers identifying pertinent considerations (Pratt & Lamson, 2011), SOR skills and competencies (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023), and current practices of SORs (Giresunlu et al., 2024; Ogbeide et al., 2024) in IBH and IPC settings. However, the current literature also suggests that there are unmet supervision needs of BHPs in IBH settings (Kracen et al., 2023; Li et al., 2022). These results of this current study could serve as a framework for designing supervisory experiences to ensure that novice BHPs are receiving training that is practical and enhances their professional efficacy in IPC settings. Additionally, this can provide IPC SORs with a tool for responding to SEE challenges as they arise, identifying themes in SEE experiences related to the needs identified by an expert panel of their peers. Finally, this can serve as an important evaluative tool for supervision. SORs can engage in self-reflection and reflection of their supervision facilitation to ensure that all pertinent supervisory needs have been met. This can also be used in conjunction with formal evaluation of

the supervision experience, allowing for SEEs to provide feedback to the SOR on whether their needs were met and how supervision can be enhanced moving forward.

It is likely that each of the supervisory needs identified by expert panelists is interconnected, as statements in the *Supervisor Characteristics* and *The Supervisory Experience* themes will affect each of the other statements. Therefore, IPC SORs would benefit from focusing a significant amount of energy towards process-oriented components of the supervision experience, including building fruitful SOR-SEE relationships, reflecting upon experiences as BHPs in IPC settings, and using the supervision relationship as an intervention towards professional growth. The use of developmental (e.g., Integrative Developmental Model) and integrative (e.g., Discrimination Model) supervision theories to conceptualize supervision in IPC settings may be an important orientation, as it may allow for the SOR to tailor supervision interventions and experiences to facilitate a seamless transition into the IPC setting. For example, SEE's in their initial weeks of transition in an IPC setting may get the most benefit from supervision if it is focused on orientation to the roles and practices of BHPs in IPC in the clinic (*The Supervisory Experience*, *Clinic-Specific Orientation*), sharing of expectations and challenges associated with IPC (*The Supervisory Experience*), exploring the model of IPC utilized (*Supervisor Knowledge & Training*), exploring strategies for building relationships with interdisciplinary members of the IPC team (*Interdisciplinary Training*), differentiating between traditional psychotherapy and consultant work common in IPC settings (*Clinical Training*), and reviewing pertinent ethical and cultural considerations (*Additional Supervisory Needs*). As they have progressed as a behavioral health professional in IPC, the SOR may then transition to more advanced topics, including empirically supported treatments for behavioral health and medicine concerns (*Clinical Training*), strategies for educating medical providers on behavioral health

concerns (*Interdisciplinary Training*), behavioral medicine and somatic dimensions of behavioral health concerns (*Medical Training*), pharmacological considerations (*Medical Training*), and ongoing professional growth outside of the IPC setting (*Professional Development*).

Expert panelists indicated various supervisory needs of novice BHPs in IPC settings that relate to the reception and integration of information necessary to perform clinical, administrative, and interprofessional responsibilities. This indicates a need for IPC SORs to have the ability to effectively teach novice BHPs the necessary skills and knowledge to function effectively as a part of an IPC team. The importance of teaching in supervision, particularly through modeling, has been identified as an important competence and process in the IPC supervision literature (Giresunlu et al., 2024; Ogbeide & Bayles, 2023; Ogbeide et al., 2024). Specifically, IPC SORs would benefit from developing competence in methods for teaching clinical and administrative skills to promote BHP competence in IPC settings. The use of developmental (e.g., Integrative Developmental Model), integrative (e.g., Discrimination Model), and theory-based (e.g., Cognitive-Behavioral) supervision models may provide a structure for SORs to engage in modeling. The use of supervision models may allow for SORs conceptualize SEE developmental readiness, choose the best strategy, and provide targeted training related to topics identified as supervisory needs of novice BHPs in IPC settings. Due to the established need to retrain BHPs in IPC settings (Serrano et al., 2018) and the amount of information that expert panelists identified as necessary for novice BHPs in IPC settings, it becomes important that SORs in these spaces have the skillset to approach supervision conceptually and practically to promote SEE learning of IPC topics.

For SORs situated within academic institutions as a practicum and/or internship instructor, these findings can be utilized to enhance university-based supervision for novice

BHPs completing their clinical training IPC settings. While university SORs will likely not have the same level of contact with SEEs, responsibility for SEEs' clinical practice and skill development, and/or experience as a clinician or SOR in IPC settings, they may play a crucial role in the personal and professional development of novice BHPs. Therefore, this information may be used by university SORs with SEEs in IPC settings to ensure that some of their concerns, experiences, and needs are being addressed in a university setting. Some of the novice BHPs' supervisory needs identified by expert panelists in the *Supervisory Experience* and *Supervisor Characteristics* themes may be able to be met by university SORs, potentially enhancing the overall training experience. Additionally, a SOR who can effectively utilize group supervision with SEEs may create a space for normalization of challenging experiences and create professional relationships with those who share a professional identity. These may be protective experiences for novice BHPs in IPC settings especially, as professional isolation and/or disconnection with their professional identity may be common when initially integrating into these settings (Berkel et al., 2019; Li et al., 2022).

Implications for Novice Behavioral Health Providers

While the primary implications from this research relate to SORs in IPC settings, the findings can be used by novice BHPs who are planning to or have recently integrated into IPC settings. Given that novice BHPs in IPC settings have previously reported feeling overwhelmed with the expectations of their new roles and responsibilities (Li et al., 2022), supervision may be another overwhelming component to transitioning into IPC. Therefore, novice BHPs can use this data to better understand what they may expect from others who have transitioned into clinical roles in IPC settings. While all themes may be helpful for conceptualizing their incoming clinical roles, statements from the *Interdisciplinary Training*, *Clinical Training*, and *Medical Training*

may be particularly useful to orient them to their roles and responsibilities as BHPs. Additionally, novice BHPs can use this data to advocate for their needs in supervision to be met and to start a conversation with their SOR about how the supervision space contribute to a fruitful training experience. When advocating for specific needs, all items would be helpful; however, exploring specific statements in *The Supervisory Experience*, *Supervisor Characteristics*, and *Clinic-Specific Orientation* may be most helpful to explore at the onset of supervision to promote initial transitions into IPC. Other statements across the remaining themes may be used once the novice BHP perceives a strong foundation in these themes, allowing for them to receive information that aligns with their developmental readiness for supervisory needs that may be conceptualized as more advanced. By bringing the statements that expert panelists have identified as pertinent supervisory needs of novice BHPs into the supervision space, SEEs have the capacity to play a more active role in their training and professional development.

Implications for Behavioral Health Educators

Finally, this study has implications for educators across the behavioral health professions. While the results of this study are focused on supervisory needs, educators in behavioral health training programs can use this data to enhance their curricula to better prepare BHPs for future work in IPC settings. When appropriate, concepts identified by expert panelists in the *Medical Training*, *Interdisciplinary Training*, *Clinical Training*, and *Additional Supervisory Needs* can be incorporated into foundational coursework in behavioral health training programs. This may set the foundation for successful integration into IPC settings and allow for supervision to be more focused on learning and applying concepts for advanced clinical practice. Additionally, this may bolster current workforce development needs for IPC, providing students in graduate programs with exposure to IPC concepts which they can bring into their supervised experiences.

Limitations

As with any study, it is important to acknowledge limitations that may adversely impact the research process and associated results. While researchers have called for interdisciplinary healthcare research (Hesse-Biber, 2016; Smye & Frangi, 2021), the use of an interdisciplinary Delphi panel may contribute to limitations in the generalizability of results. This may be due to potential professional differences related to scope of practice, training for practice in IBH settings, and philosophical conceptualizations of behavioral health. A related concern is a lack of standardization on how long someone can be conceptualized as a novice clinician, as researchers have considered novice clinicians to have a range of months to years of experience (Schwing et al., 2011; Thériault et al., 2009). While inclusion criteria were determined to recruit novice BHPs based on predetermined levels of experience, there is a chance that some expert panelists were more developmentally advanced than others. These clinicians who meet inclusion criteria may exhibit characteristics of a clinician transitioning from Level 1 to Level 2 of the Integrative Developmental Model (Stoltenberg & McNeill, 2010). This may mean that certain expert panelists have more advanced needs in supervision and/or have less supervisory needs than others, despite matching criteria to be conceptualized as a novice BHP. These considerations may contribute to findings that are difficult to generalize to the wide range of novice behavioral health clinicians that may be present in IBH settings.

Another important set of limitations of this study lies within the Delphi panel that assembled. While an acceptable number of panelists were recruited, the entirety of the Delphi panel identified as female, and two-thirds identified as White. Although behavioral health professionals tend to be White females, the lack of gender and racial diversity may have contributed to significant limitations in the agreed upon supervisory needs of novice BHPs in

IPC settings. Additionally, there was limited representation from the clinical social work and marriage and family therapy professions. Despite earnest attempts to recruit an interdisciplinary Delphi panel representative of BHPs in IPC settings, these two crucial identities within the behavioral health professions were not as represented in this study, potentially contributing to philosophical and clinical perspectives that are vital for the effective functioning of an interdisciplinary primary care team. Another important limitation of the Delphi panel lies in expert panelist experience, as there was considerable variability. While the Mdn of providing supervised clinical services in IPC settings was 9.00 months, the range was large at 51 months, with the least experienced panelist reporting four months and the most experienced panelist reporting 55 months. While this can be explained by the difference in professional standing (i.e., master's student versus postdoctoral fellow), there is still a nonstatistically significant difference in experience. Each of these limitations in the panel makeup may contribute to challenges generalizing this data to all novice BHPs across professional identities. One final panel limitation was that the expert panelists overwhelmingly practiced through the PCBH model of care compared to the CoCM model. This may have affected statements created and agreed upon, as statements achieved consensus when using language associated with the PCBH model of care (i.e., Behavioral Health Consultant) rather than CoCM (i.e., care manager).

Another important set of limitations for this study pertains to the Delphi methodology. There is a significant lack of standardization in the development and implementation of Delphi studies, spanning issues including defining consensus, defining expert status for the Delphi panel, appropriate sample sizes, and survey creation (Ogbeide & Bayles, 2023; Strear et al., 2018; Wester & Borders, 2014). Therefore, the design of this study is based on recommendations and experiences of prior researchers (Grisham, 2009; Hsu & Sandford, 2007; Iqbal & Pipon-

Young, 2009; Neuer Colburn et al., 2015; Ogbeide & Bayles, 2023; Strear et al., 2018; Swank & Houseknecht, 2019; Wester & Borders, 2014), as well as my own experience conducting Delphi research. While the methods that I am utilized were grounded in the literature, the lack of guidance and standardization for Delphi studies may have contributed to a limitation in the methodological effectiveness. Finally, this study did not use focus groups or other interviewing strategies, which may have improved the credibility and clarity of statements. While we engaged in member checking via electronic formats, this process may have been enhanced through more direct methods of communication with expert panelists.

Future Research

Moving forward, this study may influence the development and rationale for future research within the realm of IPC supervision. Within qualitative domains, future studies may explore novice BHPs' perceptions of supervision they received in IPC settings, specifically focusing on items associated *with The Supervisory Experience and Supervisor Characteristics themes*. While the IPC supervision literature base is growing, these studies are overwhelmingly focused on the SOR (Edwards & Patterson, 2006; Giresunlu et al., 2024; Ogbeide et al., 2023a; Ogbeide et al., 2024; Ogbeide & Bayles, 2023; Pratt & Lamson, 2011). The SEE plays a crucial role in the impact and outcome of supervision, therefore future research focusing on their perceptions of IPC supervision will become imperative to ensure that IPC workforce development is progressing. A comparative analysis of SEE's experiences in supervision can occur with the data in this study, allowing for researchers to identify whether SEEs perceive supervision to be more effective and fruitful when the supervisory needs identified in this study are met. Additionally, qualitative research can explore the SOR's perception of their own practice relative to SEEs' supervisory needs in IPC settings. This may highlight ways in which

current supervision practices are currently meeting the needs of novice BHP in IPC settings identified by expert panelists who were novice BHPs in this study.

Quantitatively, this study can be paired with current competency tools associated with models of IPC, such as the Behavioral Health Consultant Core Competency Tool (BHC-CCT) outlined by Robinson and Reiter (2016). When paired with training on items in various themes (i.e., *Medical Training*, *Clinical Training*, *Interdisciplinary Training*, *Additional Supervisory Needs*) identified by the Delphi panel in this study, researchers can explore how BHP skill growth occurs when they initially transition into the IPC setting, halfway through their training, and then at the conclusion of their training. This may provide additional insight into the effectiveness of IPC supervision in pursuit of BHP competence. Related, researchers can use other assessments oriented towards theoretical fidelity (e.g., CBT, ACT, MI), interprofessional collaboration, and behavioral health integration to assess the effectiveness of clinical supervision experiences in these domains.

Future studies can also explore specific supervisory differences between models of behavioral health integration in primary care. While this study looked at two of the more common models of IPC, PCBH and CoCM, the language that achieved consensus in this study aligned more with conceptualizations of BHPs in the PCBH model (i.e., BHPs as Behavioral Health Consultants) rather than the CoCM model (i.e., BHPs as Care Managers). Therefore, a more detailed, comprehensive dive into supervision of behavioral health consultants versus care managers would be beneficial to fully grasp the supervisory needs of BHPs in each model. Due to the scope of this study, these are general needs that may be able to be generalized to some SEEs in IPC settings, yet differences may exist in the specifics of supervision in PCBH and CoCM models, particularly for the statements within the *Supervisor Knowledge & Training* and

Clinic-Specific Orientation themes. While many of the foundational skills, knowledge, and supervisory needs identified in this research may remain, future research exploring each individual model may enhance the delivery of supervision of BHPs practicing in specific models of IPC.

Finally, future research would benefit from continuing to explore training needs and experiences of both BHPs and SORs in IPC settings. Currently, SORs for present and future BHPs may be ill-equipped and trained to provide comprehensive supervisory experiences in IPC settings (Ogbeide et al., 2024). This may be problematic, as there was a wide array of supervisory needs identified by the expert panelists. SORs may understand SEE needs in IPC settings after this study, but this may not be sufficient if they are not adequately trained to provide quality supervision. Therefore, continued efforts to explore what supervisors need to provide high-quality supervision in IPC and the associated best practices for training SORs for IPC settings would be pertinent. Specific efforts to identify ways to train future IPC SORs on general supervision models (e.g., Integrative Developmental Model, Discrimination Model, Cognitive Behavioral Supervision), IPC supervision models (e.g., PARSE model) clinical teaching strategies, behavioral health integration strategies, workforce development initiatives, and opportunities for SEE and SOR professional development may be imperative to teach incoming SORs for IPC settings. Related, an exploration of current counselor education practices and the roles of behavioral health educators in developing novice BHPs and SORs for transition and practice in IPC settings may yield fruitful results.

Chapter Summary

This chapter provides an exploration into the meaningfulness of the data presented in this study. The statements generated and agreed upon by expert panelists echo the literature related to

competencies for clinical practice in IPC, what SEEs indicate currently receiving and missing from their supervision experiences, and the current literature outlining SOR competencies and practice in IPC settings. The results have implications for various stakeholder, notably SORs with novice BHPs in IPC settings, novice BHPs transitioning into IPC, and for behavioral health educators. While there are methodological and participant limitations of this study, it provides a unique perspective that provides clarity on a necessary dimension of clinical supervision while providing a starting point for future research that may shape the training of future BHPs in IPC.

CHAPTER SIX

MANUSCRIPT

Primary care has long been conceptualized as the *de facto* setting for mental health treatment in the United States healthcare system (Kessler & Stafford, 2008), with an increasing number of primary care visits incorporating patients' behavioral health concerns (Rostenstein et al., 2023). Integrated primary care (IPC) has emerged as a model of care where behavioral health providers (BHPs; i.e., clinical mental health counselors, clinical psychologists, clinical social workers, marriage and family therapists) integrate into primary care systems to provide behavioral health care to patients. When implemented, IPC has been found to be related to enhanced biopsychosocial clinical outcomes, enhanced patient satisfaction, a reduction in overall healthcare costs, and enhanced provider wellness and satisfaction (Hunter et al., 2018; Ross et al., 2019; Rowan et al., 2021; Zubatsky et al., 2020). Additionally, the integration of BHPs in primary care is largely accepted by healthcare professionals and the patients they serve (Hunter et al., 2018). Despite the evidence suggesting the effectiveness of IPC initiatives, there are a variety of challenges that BHPs experience when integrating to IPC settings. These challenges include adapting to the culture and expectations of primary care (Cox et al., 2014), conceptualizing their roles and professional identity in primary care (Berkel et al., 2019; Li et al., 2022), and a lack of training for clinical practice in IPC settings (Cox et al., 2014; Dice et al., 2022; Li et al., 2022). The lack of training is a notable challenge, as researchers have consistently indicated that workforce development and training is an obstacle for current and future IPC initiatives (Serrano et al., 2018; Hall et al., 2015).

Clinical supervision is a vital dimension of training during graduate education and postgraduate licensure attainment for BHPs across professional identities (Tugendrajch et al.,

2021), with supervision being coined as the “signature pedagogy” of the behavioral health professions (Bernard & Goodyear, 2019, p. 2). Clinical supervision is understood as both a relationship and intervention where a less experienced member of a profession will collaborate with a more experienced member to promote professional and personal growth (Bernard & Goodyear, 2019; Corey et al., 2021). This process has been found to increase self-awareness and self-efficacy of BHPs (Lohani & Sharma, 2022), reduce novice BHP anxiety (Ellis et al., 2015), and increase BHPs’ clinical confidence and effectiveness (DePue et al., 2020; Wilson et al., 2016). These findings indicate the importance of supervision in the professional growth of BHPs who are in the beginning stages of their career and may be conceptualized as novices. To enhance supervisor (SOR) skill and knowledge related to supervision, leaders and researchers have identified best practices (Borders et al., 2011) and competencies (Neuer Colburn et al., 2015) for general supervision practice, allowing SORs to provide high-quality supervision for their BHPs-in-training.

In the IPC context, the clinical supervision literature is limited but growing, echoing the importance of effective, high-quality supervision for BHPs in IPC settings (Ogbeide et al., 2023a). Currently, literature exists exploring supervisory considerations (Pratt & Lamson, 2011), SOR skills and competencies (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023), and current practices of SORs (Giresunlu et al., 2024; Ogbeide et al., 2024) in IPC and other integrated care settings. The findings presented in these studies provide SORs in IPC settings with a foundation for the provision of high-quality supervision to novice BHPs in IPC settings. However, this data may not be sufficient, as challenges associated with IPC supervision include lack of SOR competence and training, a lack of supervisee (SEE) competence and training, and ethical challenges related to primary care supervision for BHPs (Ogbeide et al., 2023a).

Additionally, researchers reported that SEEs have indicated the reception of unsatisfactory supervision in the integrated care context related to supervisory inaccessibility, inconsistency of formal supervision, missed content, lack of professional development, and disconnection from the therapeutic component of supervision (Kracen et al., 2023; Li et al., 2022). Therefore, current SOR efforts to provide effective supervision in IPC settings may not be sufficient despite current data on best practices, skills, and competencies for SORs in these settings.

The Current Study

Currently, there are limited studies on the supervision experiences of novice BHPs in IPC settings. Of the studies that do exist, participants indicated various unmet needs related to the supervision relationship, experience, and information provided (Kracen et al., 2023; Li et al., 2022). There may be a disconnect between the existing IPC supervision literature, IPC SOR practices, and the experiences and needs of novice BHPs when they transition into IPC settings. Due to the importance of clinical supervision on BHP personal and professional development, safety of patients served by novice BHPs, and protection of the behavioral health professions, this may translate to ineffective supervision that does not serve the intended purposes. In this study, thus, the authors explored the perceptions of novice BHPs' supervisory needs in IPC with the aim to assist SORs with the ability to better conceptualize clinical supervision in IPC settings, guide the supervision experience to ensure novice BHPs receive high-quality training, and evaluate the practical effectiveness of clinical supervision in the IPC context. Examining the range of supervisory needs of novice BHPs as they practice and receive clinical supervision in IPC settings, **t**he research question that guided the development and completion of this study was: What do novice behavioral health providers in integrated primary care settings identify to be their most pertinent needs in clinical supervision?

Delphi Methodology

The authors used a classical Delphi methodology (Linstone & Turoff, 1975) with several rounds of structured, anonymous communication between individuals who have expertise in the topic under investigation to achieve consensus on topics that have historically been unexplored (Iqbal & Pipon-Young, 2009; Strear et al., 2018). The classical Delphi methodology was an appropriate design for this study, as the concept of supervisory needs of novice BHPs in IPC settings is largely unresearched, has a limited empirical base, and is currently challenging to explore quantitatively. The methodology has been used to explore previously disputed and unresearched topics in supervision and behavioral health practice, including general supervisor competencies (Neuer Colburn et al., 2015), competencies for supervision in Primary Care Behavioral Health (PCBH) settings (Ogbeide & Bayles, 2023), and conceptualizations of standards for productivity in PCBH (Martin et al., 2022). Data collection for this study was conducted by the first author; data analysis was conducted by three authors (i.e., N.S., M.L., C.K.); and the writing and revision of the study was conducted by all authors.

Participants

The Delphi panel is conceptualized as the most important component of a Delphi study (Iqbal & Pipon-Young, 2009), as the expert panelists are responsible for achieving consensus on the topic under investigation. It is recommended that Delphi panels consist of a homogenous group of individuals who share a common experience, identity, and knowledge on the topic under investigation (Strear et al., 2018). Due to this, purposive sampling was utilized in this study as the ideal approach to recruiting panelists to the Delphi panel (Neuer Colburn et al., 2015). Additionally, potential expert panelists were encouraged to share recruitment information to their professional peers and colleagues, as it is likely that expert panelists have professional

relationships with other professionals who have expertise in the topic under investigation (Iqbal & Pipon-Young, 2009; Strear et al., 2018). Recruitment of expert panelists occurred over a two-month period in which expert panelists were invited and volunteered for participation in subsequent rounds of data collection. We hypothesized that this would promote reduced attrition and a more consistent schedule when conducting data collection.

To be conceptualized as an expert panelists in this study, individuals needed to meet the following inclusion criteria: 1) being a behavioral health professional in training (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education; (2) having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting; and 3) having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting. The inclusion criteria were chosen to promote expertise in the reception of supervision in an IPC setting and recruitment of expert panelists at the beginning stages of their career (i.e., graduate school, recently graduated from graduate school, postgraduate fellow). An interdisciplinary panel was chosen due to calls for interdisciplinary research in health sciences (Smye & Frangi, 2021), the conceptualization of BHP roles across professional identities are more similar than different in IPC settings (Glueck, 2015; Robinson & Reiter, 2016), and prior studies in IPC recruiting BHPs from across professional identities (Ogbeide & Bayles, 2023; Ogbeide et al., 2024).

Delphi Procedures

Classical Delphi studies use anonymous, structured communication via surveys to achieve consensus on a topic of interest, with three rounds being identified as acceptable for achieving statistical consensus (Iqbal & Pipon-Young, 2009; Strear et al. 2018) and attending to attrition related to participation in multiple surveys (Neuer Colburn et al., 2015). After gathering the Delphi panel, the authors created the survey for the first round and pilot tested it with three novice BHPs with prior experience in IPC yet were not completing clinical hours in an IPC setting at the time of the study. Pilot testing has been identified as an important component of Delphi studies to promote clarity, readability, and appropriateness of the survey in relation to the aim (Iqbal & Pipon-Young, 2009; Strear et al., 2018). The pilot testers provided three feedback statements and three comments related to the readability and clarity of the first survey, which were integrated into the final draft of the survey provided to expert panelists in Round 1.

Round 1

The first survey is meant to start the process of generating statements related to the topic of interest. The first part of this survey consisted of nine questions pertaining to relevant information about the expert panelists (e.g., age, race, gender, professional identity) to contextualize the answers within expert panelists' personal and professional identities. Additionally, the authors provided one open-ended questions with nonspecific prompts to assist with generation for up to 50 statements in sentence format pertaining to the supervisory needs of novice BHPs in IPC settings. An open-ended question (i.e., Based on your experience as a clinician in an Integrated Primary Care setting, what do new behavioral health clinicians need in supervision to enhance their practice in Integrated Primary Care?) was chosen to encourage expert panelists to brainstorm, allowing the lived experiences of expert panelists as novice BHPs receiving supervision in IPC settings to guide the generation of statements and ideas (Hsu &

Sandford, 2007; Iqbal & Pipon-Young, 2009). Data analysis of the first survey included descriptive statistical analysis of the demographic information and open and axial coding procedures (Corbin & Strauss, 2015) for the open-ended question. Qualitative analysis was conducted by two researchers (N.S. & M.L.). Procedures for open coding included identification of initial emergent themes and grouping thematically similar statements into these emergent themes, with procedures for axial coding included the clarification and categorization of these themes (Corbin & Strauss, 2015; Williams & Moser, 2019). In the axial coding process, the authors collapsed and combined thematically similar statements into a series of nonredundant, coherent statements (Neuer Colburn et al., 2015) while maintaining expert panelist language to preserve the intended meaning of the generated statements (Strear et al., 2018). After axial coding procedures, statements were provided to a third researcher (C.K.), who served as an internal auditor and provided feedback on the statements. Axial coding procedures were repeated after reviewing feedback from the third author.

Round 2

The goal of Round 2 was to start the process of achieving consensus on the statements that were generated from Round 1, as per best practices for Delphi studies (Hsu & Sandford, 2007). Each item on the survey was a statement created by expert panelists during Round 1, followed by a six-point Likert scale indicator of agreement (i.e., 1 = strongly agree to 6 = strongly disagree) and open-ended spaces for expert panelists to indicate suggestions for revisions and/or removal of statements depending on level of agreement (Neuer Colburn et al., 2015; Ogbeide & Bayles, 2023; Swank & Houseknecht, 2019). At the conclusion of the survey, participants were provided with a copy of the statements with an opportunity to generate new statements that they believe were missing after Round 1. Data analysis for Round 2 followed

statistical analysis to indicate consensus, which were defined *a priori* as a Median (Mdn) of ≤2.00 and an Interquartile Range (IQR) of ≤1.00, with Mdn and IQR being identified as appropriate statistical indicators of consensus in prior Delphi research (Swank & Houseknecht, 2019). All statistical analyses were conducted using the SPSS Statistics software (IBM, n.d.). For items that did not achieve consensus and were amended and/or added, qualitative procedures were the same from Round 2. Two researchers (N.S. & C.K) conducted the primary analysis, a third researcher (M.L.) serving as an internal auditor.

Round 3

Round 3 was the final round, with the purpose of finalizing consensus among items generated by expert panelists through responding to items that were revised and/or added during Round 2. The same Likert-scale and statistical indicators of consensus were utilized. Upon completion of this survey, each participant was given the space to provide their email to receive a $50 Amazon eGift Card, which was provided through grant funding via a regional professional membership organization. Data analysis of Round 3 followed statistical analyses and indicators of consensus utilized for Round 2.

Validity and Trustworthiness

Due to the qualitative nature of Delphi studies, the use of strategies to enhance validity and trustworthiness of findings is imperative. The authors engaged in a variety of trustworthiness strategies, including using a research team to promote various perspectives, triangulation of researchers, reflexivity strategies (i.e., creating reflexivity statements, identifying pertinent experiences and biases related to the topic), prolonged engagement with raw and coded data, keeping memos and field notes of qualitative analysis procedures, and member checking via email as needed (Goodman-Scott & Cholewa, 2023; Neuer Colburn et al., 2015; Strear et al.,

2018). Three researchers engaged in qualitative analysis and created reflexivity statements to promote validity and trustworthiness. N.S. is a 26-year-old Cisgender, Caucasian male. He is a Ph.D. candidate in Counselor Education and Supervision and has extensive clinical, supervisory, educative, leadership, and scholarly experience in IPC settings. M.L. is a 30-year-old Cisgender, Caucasian female. She is a Ph.D. student in Counselor Education and Supervision working towards clinical licensure and has extensive experience in medical settings as a clinical mental health counselor and as a registered nurse. C.K. is a 23-year-old Cisgender, Caucasian female. She is a first year Ph.D. student in Counselor Education and Supervision and has experience as a clinical mental health counselor in private practice settings.

Results

Sixteen expert panelists were invited to participate in this Delphi study after they indicated meeting all three components of the inclusion criteria during the recruitment phase. Of these expert panelists, 12 (75%) responded to the Round 1 survey. All 12 expert panelists completed every round of this study, indicating a retention rate of 100% between Rounds 1 and 3. The Delphi panelists all identified as Cisgender females (100%), with the majority also identifying as Caucasian (66.7%), from the clinical psychology profession (58.3%), and current doctoral students (41.7%). Related to their clinical practice as a novice BHP, they indicated a median of 9.00 months providing direct clinical services, ranging from four to 55 months. Expert panelists primarily indicated that their supervisor shared their professional identity (75%) and practiced from the PCBH model (83.3%). Finally, most expert panelists indicated completing coursework on IPC or integrated behavioral health topics (75%) and a little over half indicated completing coursework on supervision (58.3%). See Table 1 for the full demographic information of expert panelists.

At the conclusion of Round 3, expert panelists indicated 68 statements related to the supervisory needs of novice BHPs in IPC settings. These statements were spread across nine themes: 1) *The Supervisory Experience* included 19 statements that span behaviors of the supervisor and/or supervisee that enhance the function, relationship, and overall experience of supervision; 2) *Supervisor Characteristics* included 11 statements that expand upon enduring traits and characteristics or supervisors that may contribute to a meaningful supervisory experience; 3) *Supervisor Knowledge & Training* included five statements that identify specialized knowledge and training about clinical practice in IPC settings that supervisors would benefit from possessing; 4) *Interdisciplinary Training* included four statements that span training that novice BHPs would benefit from receiving in supervision related to clinical practice, communication, and collaboration in an interdisciplinary setting; 5) *Medical Training* included nine statements that identify training related to basic medical dimensions of behavioral health practice in IPC settings that novice BHPs would benefit from receiving during supervision; 6) *Clinic-Specific Orientation* included seven statements related to information that novice BHPs would benefit from receiving to enhance their conceptualization of behavioral health and integration in the specific primary care setting; 7) *Clinical Training* included six statements related to specific clinical training provided by the supervisor that may enhance the novice BHPs' ability to effectively provide behavioral health services in IPC settings; 8) *Professional Development* included three statements that identified professional growth and development that novice BHPs would benefit from receiving during supervision; and 9) *Additional Supervisory Needs* included four statements that were not thematically similar to other statements but were conceptualized as vital supervisory needs of novice BHPs in IPC settings. Two statements, one from *Supervisor Characteristics* and one from *Supervisor Training & Knowledge*, did not

receive consensus at the conclusion of Round 3. See Table 2 for the final list of statements with associated statistical indicators of consensus.

Discussion

At the conclusion of this study, expert panelists identified nine themes related to the pertinent supervisory needs of novice BHPs in IPC settings. This study is uniquely placed in the context of other IPC supervision literature because interdisciplinary, novice BHPs were conceptualized as experts in the reception of clinical supervision and identified what they perceived to be the most pertinent supervisory needs of novice BHPs in IPC settings based on their own experience. Due to components of the Delphi study, this study adds to the literature by bringing an objective dimension to the subjective experiences and perceptions of novice BHPs in IPC settings through statistical analysis outlining consensus. Finally, this study expands upon existing literature that identified BHPs' perspectives of supervision in IPC and integrated care settings, providing specificity and clarity on a wide range of supervisory needs of novice BHPs in IPC settings.

Expert panelists indicated various statements that encapsulate foundational factors affecting supervision. In *The Supervisory Experience* theme, expert panelists indicated the importance of a perception of trust, openness, ongoing communication, addressing of cultural identities, constructive evaluation, and responding to potential resistance, all of which have been identified as an important component of a meaningful supervision experience (Bernard & Goodyear, 2019; Corey et al., 2021; Neuer Colburn et al., 2015). Additionally, items in the *Supervisor Characteristics* theme identified by expert panelists highlight the importance of supervisor openness to trainee experiences and goals, nonjudgement, approachability, flexibility, and awareness of cultural factors. These characteristics have been identified in prior supervision

literature as important for general supervisory practice (Bernard & Goodyear, 2019; Borders et al., 2011; Corey et al., 2021; Neuer Colburn et al., 2015). While this study was specifically exploring the supervisory needs of novice BHPs in IPC settings, expert panelists indicated the importance of foundational dimensions of the supervision experience and supervisor that are imperative for trainee development.

While expert panelists indicated items that are foundational to effective supervision practice across settings, most statements generated were specific to the needs of novice BHPs in IPC settings. In *The Supervisory Experience* theme, expert panelists indicated the importance of a supervisor who provides opportunities for the novice BHP to shadow their clinical and professional encounters, moments of advocacy for the behavioral health team in IPC, dedication of adequate time for supervision requirements despite a busy IPC schedule, and an orientation to the role of the BHP in the IPC setting. Literature indicates the benefits of shadowing and a comprehensive orientation to IPC settings due to the significant deviation from traditional mental health work (Li et al., 2022; Serrano et al., 2018), as well as the importance of supervisor availability for supervision despite a lack of availability from supervisors in integrated care settings (Kracen et al., 2023; Li et al., 2022). Additionally, expert panelists indicated the importance of supervisor openness to sharing their own experiences as a novice BHP in IPC settings, highlighting *Supervisor Characteristics* that may be influenced by the specific IPC context. Due to the multidimensional challenges associated with BHP transition into IPC settings, this may prove to be a vital moment for personal and professional development in novice BHPs while simultaneously normalizing transitional challenges. The provision of needs associated with *The Supervisory Experience* theme by a supervisor who embodies the *Supervisor*

Characteristics identified as necessary in this study may contribute to a fruitful relationship that is accompanied by high-quality supervision for IPC.

Not surprisingly, expert panelists indicated the importance of supervisors possessing specific knowledge and training pertaining to IPC in the *Supervisor Training & Knowledge theme*, including knowledge of PCBH having experience practicing as a generalist in IPC settings, and understanding clinical and philosophical orientations to care. Each of these items are represented in prior IPC supervision literature, with Ogbeide and Bayles (2023) highlighting these in their supervisor competencies for PCBH settings. Supervisors having this professional foundation of practice for IPC may contribute to a more effective supervisory space, as supervisors can call upon their own experience and expertise to enhance supervision. This may also allow for supervisors to better understand the nuances behind the context of IPC settings.

Due to the context of IPC, expert panelists highlighted the supervisory needs of novice BHPs related to *Interdisciplinary Training* and *Medical Training*. Prior researchers have consistently identified novice BHPs in IPC settings experiencing challenges related to interprofessional collaboration and communication (Cox et al., 2014; Dice et al., 2022) and a lack of training on basic medical concepts and topics (Glueck, 2015; Li et al., 2022). This study further specifies the importance that novice BHPs receive training in supervision related to educating medical providers on behavioral health topics, building and maintaining interdisciplinary relationships, effective strategies for interprofessional communication, somatic experiences of behavioral health concerns, common health conditions, medications, and medical settings and culture. These findings suggest the importance of providing novice BHPs with the space in supervision to learn about ways to incorporate interprofessional skills and basic medical

knowledge into clinical practice in IPC settings, as they may contribute to enhanced clinical comfort and effectiveness in these spaces.

Like specialty mental health settings, there will likely be significant variability between IPC clinics, affecting clinical and interprofessional practices, philosophical orientation to healthcare, and the model and level of integration (Giresunlu et al., 2024; Heath et al., 2013). Therefore, expert panelists indicated the importance that novice BHPs in these settings receive ample information on the clinic they are transitioning into to enhance their own integration, providing insight into the *Clinic-Specific Orientation* needs of novice BHPs in IPC settings. This information may include policies and procedures, effective use of the technology used by the clinic, clinic culture and dynamics, patients being served, and ways to practice as a behavioral health provider in IPC. Each of these statements may provide novice BHPs with the foundation for understanding how they can best fit into the clinic and provide behavioral health care to patients. Additionally, an understanding of clinical practices (e.g., warm handoffs) and administrative skills (e.g., documentation) necessary for integration in IPC settings is important (Robinson & Reiter, 2016). For novice BHPs in IPC settings, information that is specific to the clinic they are transitioning into appears as an imperative need, as it may contribute to effectiveness of integration.

Prior researchers have indicated the significant difference in clinical practice in specialty mental health settings compared to IPC settings, contributing to a need for extensive retraining (Serrano et al., 2018). New BHPs across integrated care settings have reported challenges adapting to practice expectations, namely the provision of targeted, empirically supported behavioral health assessment and intervention within the fast-paced context of IPC. Expert panelists indicated supervisory needs related to *Clinical Training*, namely the reception of

information on the difference between traditional mental health practice and clinical practice in IPC settings, including the treatment approaches and therapeutic skills that are generally accepted for IPC settings (i.e., Cognitive Behavior Therapy, Acceptance and Commitment Therapy, Motivational Interviewing). Notably, expert panelists indicated the need for novice BHPs to have a strong foundation in risk assessment and treatment of grief and loss, which may be supplemented by supervision-based training. This reinforces prior literature indicating the importance of supervisors being able to conceptualize behavioral health practice in IPC (Ogbeide & Bayles, 2023), while providing specificity on the need to train novice BHPs in empirically supported interventions for the wide range of presenting concerns their patients may be experiencing, including safety concerns and grief.

Related to *Professional Development*, panelists indicated the importance of BHPs receiving information regarding ongoing professional development in IPC settings. Prior researchers have indicated professional development being a missing piece of supervision in integrated care (Kracen et al., 2023), with this study reinforcing the need for novice BHPs to receive information, guidance, and encouragement from their supervisor towards professional development. In the context of this study, this may include opportunities outside of licensure to grow as a BHP in primary care, which may include being involved in conferences, research, and professional organizations.

Finally, expert panelists indicated *Additional Supervisory Needs* that did not fit with other themes, including training in ethical and cultural dimensions of being a BHP in an IPC setting, encouragement to supervise as a future supervisor, and understandings of community resources. Integration of ethical and cultural considerations in IPC supervision has been previously identified in the literature (Giresunlu et al., 2024; Kracen et al., 2023; Ogbeide et al., 2024).

These findings reinforce the importance of ongoing exploration and integration of ethical and cultural dimensions of IPC practice into the supervision experience for novice BHPs. Understanding and application of community resources during treatment has been identified as an important competency for IPC practice (Robinson & Reiter, 2016), indicating the benefit for supervisors to provide this information to novice BHPs in these settings. Finally, encouragement to supervise in the future was identified as pertinent for novice BHPs, as this may contribute to future clinicians interested in developing the behavioral health workforce for primary care and provide a foundation of training for supervision through observation. Kracen and colleagues (2023) indicated that the development of supervision skills during supervision in integrated care was missing from BHP experiences, highlighting the importance that novice BHPs can learn about how to supervise from their own supervision experience.

Implications

Implications for Supervisors

The results of this study have considerable implications for supervisors currently providing supervision to novice BHPs in IPC settings. Most notably, this research provides supervisors with a framework for structuring, delivering, and evaluating the effectiveness of clinical supervision in IPC. Currently, the literature for supervision in IPC settings is growing, with researchers identifying supervisory considerations (Pratt & Lamson, 2011), skills and competencies for supervisors (Edwards & Patterson, 2006; Ogbeide & Bayles, 2023), and current practices of supervisors in integrated care settings (Giresunlu et al., 2024; Ogbeide et al., 2024). Despite this, BHPs have indicated unmet supervisory needs during their integrated care supervision experiences (Kracen et al., 2023; Li et al., 2022). Moving forward, supervisors could use these findings to conceptualize what novice BHPs may conceptualize to be their most

pertinent supervisory needs when initially transitioning into IPC settings, allowing for basic needs to be addressed (e.g., orientation to primary care, information about the clinic policies and procedures, differentiation between specialty mental health and IPC) immediately and more advanced needs to be met when developmentally appropriate. This data might also provide insight into how to structure supervision to preemptively address challenges that are commonplace for novice BHPs in IPC. In the supervision session, supervisors can utilize these findings to identify pertinent knowledge they can impart, interventions they can facilitate, and/or characteristics that they can embody to promote a meaningful, comprehensive supervisory experience and relationship.

Expert panelists indicated various supervisory needs of novice BHPs in IPC that identify the reception and integration of information necessary to perform the responsibilities associated with a BHP in IPC settings. This indicates the need for IPC supervisors to have the ability to effectively teach novice BHPs the necessary skills and knowledge to function effectively as a part of an IPC team that provides biopsychosocial care. Teaching strategies, particularly modeling, have been identified as an important component and skill for supervision in IPC (Giresunlu et al., 2024; Ogbeide & Bayles, 2023; Ogbeide et al., 2024). Teaching in supervision may allow for novice BHPs to receive the retraining that researchers have identified as necessary in IPC throughout the supervision process. Supervisors in IPC settings may benefit from having the foundation for conceptualizing supervision through developmental, theory-based, and integrative models (Ogbeide et al., 2024). These models of supervision may provide IPC supervisors with the basis for teaching the various skills and knowledge necessary through a conceptualization of the novice BHP's needs, developmental level, and preferential style of receiving teaching interventions in supervision.

Implications for Educators

While this study's data is focused on supervisory needs and primarily has implications for supervisors, educators can use this data to enhance the preparation of novice BHPs and supervisors in IPC settings. For novice BHPs, educators can use this data to enhance their conceptualization of what skills and knowledge are needed for effective transition into these settings, then incorporating this information into coursework. When appropriate, concepts in the *Medical Training*, *Interdisciplinary Training*, *Clinical Training*, and *Additional Supervisory Needs* themes identified by expert panelists can be integrated into coursework to provide novice BHPs with a strong foundation when transitioning into IPC. For IPC supervisors, this data can be used by educators to enhance the preparation of supervisors. Training for supervisors in IPC settings is currently limited yet identified as an important area of future scholarly and academic initiatives (Ogbeide et al., 2024). Supervisor educators can use this data to structure training for supervisors providing supervision in IPC settings. This, when paired with other research on supervisor competencies for IPC settings (Ogbeide & Bayles, 2023) may allow for IPC supervisors to have a stronger foundation in the skills necessary to provide high-quality supervision in IPC.

Implications for Novice Behavioral Health Providers

This study also has implications for novice BHPs who are transitioning into IPC settings. Novice BHPs have indicated the sense of being overwhelmed in integrated care settings due to new expectations, roles, and responsibilities (Li et al., 2022), which may be exacerbated when the expectation of supervision is an added component. Additionally, many novice BHPs may not be aware of what their supervisory needs are when initially transitioning into a new site. Novice BHPs can use this data to conceptualize what they may need from supervision throughout their

time as a supervisee in an IPC setting. This may also allow for them to advocate for their needs in supervision, allowing for a more open dialogue with their supervisor on what they would like to see in the supervision process and relationship. By bringing the statements identified in this study into their supervision process, novice BHPs may be able to take a more active role in the supervision process and consequently, their training and professional development.

Limitations

While this data presents a new perspective on the supervisory needs of novice BHPs in IPC settings and has the capacity to enhance the supervision process in IPC, there are important limitations to acknowledge. First, the Delphi panel may be an important limitation, as the expert panelists were all female, primarily White, and practiced from the PCBH model. Additionally, there were fewer expert panelists from the clinical social work and marriage and family therapy professions, indicating that two primary behavioral health professions were not adequately represented in the Delphi panel. This may mean that the findings are not generalizable to all novice BHPs in IPC settings due to the limited cultural and professional diversity in the Delphi panel. Another important limitation could be the interdisciplinary panel, as there have historically been considerable differences in the scope of competence and practice among the different behavioral health professions. However, this may also be conceptualized as a strength of this study, as there was representation of perspectives across professional identities that achieved consensus, potentially reinforcing the perspective that BHPs in IPC settings tend to have more similarities in professional roles and responsibilities when compared to specialty mental health (Glueck, 2015; Robinson & Reiter, 2016). Another important limitation lies within the methodology, as there is a lack of standardization in Delphi procedures (Strear et al., 2018). While these procedures were grounded in the literature, the lack of standardization may have

contributed to limitations in the results. Finally, this study could have been improved with the use of more intensive qualitative procedures, such as individual interviews and/or focus groups. While the authors engaged in member checking via email, the context and meaning of statements may have been improved with additional qualitative data collection procedures.

Future Research

Moving forward, this study may impact future scholarly initiatives focused on IPC supervision. Future research would benefit from continuing to research the supervisee's perspective of their supervision experience, potentially in relation to needs identified in this study that were and were not met in the process. Additionally, future research focused on the training of IPC supervisors would greatly benefit the field, as current IPC supervisors may be ill-equipped to provide high-quality supervision. This may entail exploring the needs of IPC supervisors and the practices of educators in developing supervisors for IPC settings. Finally, further research into supervision across IPC models (e.g., PCBH, CoCM) will be beneficial to ensure that each novice BHP in an IPC setting receives supervision that matches the context of behavioral health services that are provided.

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APPENDIX A

INFORMED CONSENT DOCUMENT

STUDY TITLE: Supervision Needs of Novice Behavioral Health Clinicians in Integrated Primary Care Settings: A Delphi Study

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those of say YES. This study seeks to achieve consensus on what behavioral health clinicians in training perceive to be their supervisory needs as they receive clinical supervision in integrated primary care settings. This is a dissertation study conducted by Nic Schmoyer, M.S. Gülşah Kemer, Ph.D. is the dissertation chair for this study.

RESEARCHERS

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DESCRIPTION OF RESEARCH STUDY

Supervision is a vital dimension of training of behavioral health clinicians, and with the rise in acceptance of integrated behavioral health in primary care, supervision within integrated primary care settings becomes imperative. Researchers have identified necessary competencies for supervisors in these settings and the challenges associated with behavioral health clinicians in integrated primary care settings. However, little attention has been given towards the needs of supervisees and novice clinicians in integrated primary care. The aim of this study is to gather consensus on what the supervisory needs of behavioral health clinicians in training as they receive clinical supervision while practicing in integrated primary care settings.

If you say YES, you will be responding to a series of three anonymous questionnaires over the course of the next two to four months. Each survey will take approximately 10-30 minutes. You may stop participation in the study at any time. If you do not wish to participate in the study, do not click on the Qualtrics link provided.

INCLUSION CRITERIA

1. Being a behavioral health professional (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education.
2. Having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting.
3. Having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting.

EXCLUSION CRITERIA

You are not eligible to participate in this study if:

a. You are a licensed behavioral health clinician.
b. You have not received clinical supervision within an integrated primary care setting.
c. You are not in a behavioral health clinician graduate training program.
d. You are more than six months past graduating from your graduate training program for behavioral health clinicians.

There are no exclusion criteria on the basis of socioeconomic status, sexual preference, race, gender, religious affiliation, or other demographic other than age.

RISKS AND BENEFITS

Risks: There are minimal risks associated with this study. Potential risks may include general discomfort or distress related to your experience receiving supervision as a novice clinician in an integrated primary care setting.

Benefits: There is no direct benefit to you for participating in this study. Others may benefit by an increased understanding of behavioral health clinicians' supervisory needs in an effort to enhance the preparation of behavioral health clinicians for effective practice in integrated primary care settings.

COSTS AND PAYMENTS

The researchers are excited to offer a minimum of $30 per participant who completes all three rounds of data collection. This payment will be provided in the form of an Amazon e-Gift Card to be sent directly to your email by Nic Schmoyer. This funding was made possible by the 2023 Southern Association for Counselor Education & Supervision (SACES) Research & Best Practice Grant.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participation, they will inform you of this new information.

CONFIDENTIALITY

The researchers will take reasonable steps to keep private information, including demographic information and interview responses, confidential. The demographic survey will not ask you to disclose personally identifiable information outside of contact information. All communication will take place via email by the primary researcher, Nic Schmoyer. All collected and analyzed data will be kept in Microsoft OneDrive, an encrypted software, and available only to the research team. The results from this study may be used in reports, presentations, and publications, but the researcher(s) will not identify you.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO at any point during the research process, including during the individual interview. Your decision to participate or withdraw will not affect your personal or professional relationships with anyone involved in the research study.

COMPENSATION

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of significant distress arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Nic Schmoyer at 570-850-6795, Dr. Gülşah Kemer at 757-683-3225**,** Dr. John Baaki - the current Human Subjects Review Committee and IRB Chair in the Darden College of Education and Professional Studies at Old Dominion University - at jbaaki@odu.edu or 757-683-5491, or the Old Dominion University Office of Research at 757-683-3460 who will be glad to review the matter with you.

VOLUNTARY CONSENT

By clicking the button at the bottom of this page, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them: Nic Schmoyer (nschm005@odu.edu) and Dr. Gülşah Kemer (gkemer@odu.edu).

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. John Baaki, the current Human Subjects Review Committee and IRB Chair in the Darden College of Education and Professional Studies at Old Dominion University, at jbaaki@odu.edu or 757-683-5491, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by clicking the button below, you are telling the researcher YES, that you agree to participate in this study, meet all inclusion criteria and are over the age of 18. If you are under 18 years of age, a parent or legal guardian must be present and provide consent for you. If possible, please print a copy of this form for your records.

I confirm that I am at least 18 years of age or I am a parent/ legal guardian and wish to participate in this study.

APPENDIX B

INVITATION TO PARTICIPATE

SUBJECT: Integrated Primary Care Dissertation Participants Wanted

Good afternoon:

I am seeking participants for my dissertation titled ***Supervision Needs of Novice Behavioral Health Clinicians in Integrated Primary Care Settings: A Delphi Study*** to learn more about the supervisory needs of behavioral health clinicians transitioning into clinical practice in integrated primary care settings. As a result of this study, I hope to better assist supervisors, educators, and leaders in the behavioral health professions structure supervision and training opportunities to ensure that clinicians are adequately prepared for practice as behavioral health providers in primary care settings.

The inclusion criteria for this study are:

1. Being a behavioral health professional (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education.
2. Having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting.
3. Having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting.

We are happy to announce that we will be offering at least $25 to all participants who complete all three rounds of surveys in this study.

If this topic is important to you and you are interested in participating in this research, please respond to this **Qualtrics link** by ***November 21st, 2023***.

Link: ***https://odu.co1.qualtrics.com/jfe/form/SV_9tBd6hfnwEw5qiW***

The current research was approved by Old Dominion University Institutional Review Board (2098056-3). If you have any questions, please do not hesitate to reach out to me (nschm005@odu.edu) and my dissertation chair, Dr. Gülşah Kemer (gkemer@odu.edu).

Have a great day!

--

Nic Schmoyer, M.S., Doctoral Candidate
Gülşah Kemer, Ph.D., NCC, ACS, Dissertation Chair

APPENDIX C

ROUND 1 QUESTIONNAIRE

INFORMED CONSENT

STUDY TITLE. Supervision Needs of Novice Behavioral Health Clinicians in Integrated Primary Care Settings: A Delphi Study

INTRODUCTION.
The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those of say YES. This study seeks to achieve consensus on what behavioral health clinicians in training perceive to be their supervisory needs as they receive clinical supervision in integrated primary care settings. This is a dissertation study conducted by Nic Schmoyer, M.S. Gülşah Kemer, Ph.D. is the dissertation chair for this study.

RESEARCHERS.
Gülşah Kemer, Ph.D., NCC, ACS. Old Dominion University, Department of Counseling & Human Services, College of Education & Professional Studies. Primary Investigator and Dissertation Chair, gkemer@odu.edu, 2100 New Education Building.
Nic Schmoyer, M.S. Old Dominion University, Department of Counseling & Human Services, College of Education & Professional Studies. Co-Investigator, nschm005@odu.edu, 2100 New Education Building.
Megan LaLonde, M.A., RN. Old Dominion Department of Counseling & Human Services, College of Education & Professional Studies. Investigator, mlalo001@odu.edu, 2100 New Education Building.
Catalina Kraft, M.A. Old Dominion Department of Counseling & Human Services, College of Education & Professional Studies. Investigator, ckraf001@odu.edu, 2100 New Education Building.

DESCRIPTION OF RESEARCH STUDY.
Supervision is a vital dimension of training of behavioral health clinicians, and with the rise in acceptance of integrated behavioral health in primary care, supervision within integrated primary care settings becomes imperative. Researchers have identified necessary competencies for supervisors in these settings and the challenges associated with behavioral health clinicians in integrated primary care settings. However, little attention has been given towards the needs of supervisees and novice clinicians in integrated primary care. The aim of this study is to gather consensus on what the supervisory needs of behavioral health clinicians in training as they receive clinical supervision while practicing in integrated primary care settings.
If you say YES, you will be responding to this recruitment survey followed by a series of three anonymous questionnaires over the course of the next two to four months. Each survey will take approximately 10-30 minutes. You may stop participation in the study at any time. If you do not wish to participate in the study, do not click on the Qualtrics link provided.

INCLUSION CRITERIA.

1. Being a behavioral health professional (e.g., clinical mental health counselor, clinical psychologist, clinical social worker, marriage and family therapist) who is completing or has completed their supervised internship in an integrated primary care setting as part of their graduate education.
2. Having completed at least one semester of a behavioral health internship or has no more than six months of uninterrupted experience after graduation providing direct clinical services to patients in an integrated primary care setting.
3. Having receive(d) weekly individual and/or triadic supervision as a behavioral health internship student in an integrated primary care setting.

EXCLUSION CRITERIA.
You are not eligible to participate in this study if:
a. You are a licensed behavioral health clinician.
b. You have not received clinical supervision within an integrated primary care setting.
c. You are not in a behavioral health clinician graduate training program.
d. You are more than six months past graduating from your graduate training program for behavioral health clinicians.

There are no exclusion criteria on the basis of socioeconomic status, sexual preference, race, gender, religious affiliation, or other demographic other than age.

RISKS AND BENEFITS
Risks: There are minimal risks associated with this study. Potential risks may include general discomfort or distress related to your experience receiving supervision as a novice clinician in an integrated primary care setting.
Benefits: There is no direct benefit to you for participating in this study. Others may benefit by an increased understanding of behavioral health clinicians' supervisory needs in an effort to enhance the preparation of behavioral health clinicians for effective practice in integrated primary care settings.

COSTS AND PAYMENTS.
The researchers are excited to offer a minimum of $30 per participant who completes all three rounds of data collection. This payment will be provided in the form of an Amazon e-Gift Card to be sent directly to your email by Nic Schmoyer. This funding was made possible by the 2023 Southern Association for Counselor Education & Supervision (SACES) Research & Best Practice Grant.

NEW INFORMATION.
If the researchers find new information during this study that would reasonably change your decision about participation, they will inform you of this new information.

CONFIDENTIALITY.
The researchers will take reasonable steps to keep private information, including demographic information and interview responses, confidential. The demographic survey will not ask you to disclose personally identifiable information outside of contact information. All communication will take place via email by the primary researcher, Nic Schmoyer. All collected and analyzed

data will be kept in Microsoft OneDrive, an encrypted software, and available only to the research team The results from this study may be used in reports, presentations, and publications, but the researcher(s) will not identify you.

WITHDRAWAL PRIVILEGE.
It is OK for you to say NO. Even if you say YES now, you are free to say NO at any point during the research process, including during the individual interview. Your decision to participate or withdraw will not affect your personal or professional relationships with anyone involved in the research study.

COMPENSATION. If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of significant distress arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Nic Schmoyer at 570-850-6795, Dr. Gülşah Kemer at 757-683-3225, Dr. John Baaki - the current Human Subjects Review Committee and IRB Chair in the Darden College of Education and Professional Studies at Old Dominion University - at jbaaki@odu.edu or 757-683-5491, or the Old Dominion University Office of Research at 757-683-3460 who will be glad to review the matter with you.

VOLUNTARY CONSENT. By clicking the button at the bottom of this page, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them: Nic Schmoyer (nschm005@odu.edu) and Dr. Gülşah Kemer (gkemer@odu.edu). If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. John Baaki, the current Human Subjects Review Committee and IRB Chair in the Darden College of Education and Professional Studies at Old Dominion University, at jbaaki@odu.edu or 757-683-5491, or the Old Dominion University Office of Research, at 757 683 3460.

And importantly, by clicking the button below, you are telling the researcher YES, that you agree to participate in this study, meet all inclusion criteria and are over the age of 18. If you are under 18 years of age, a parent or legal guardian must be present and provide consent for you. If possible, please print a copy of this form for your records.

a. I agree to voluntarily participate in this study
b. I do not agree to voluntarily participate in this study

--

Please complete the following Demographic Questionnaire.

2. Please indicate the best email to contact you for subsequent rounds:
    a. _____

3. What is your age?
    a. _____
4. How would you describe yourself?
    a. Caucasian
    b. Black or African American
    c. Hispanic, Latino, or of Spanish Origin
    d. Native American or Alaska Native
    e. Native Hawaiian or Other Pacific Islander
    f. Asian
    g. Multiracial
    h. Other (please specify)
        - _____
5. What is your gender identity?
    a. Cisgender Male
    b. Cisgender Female
    c. Trans Male or Trans Man
    d. Trans Female or Trans Woman
    e. Non-Binary
    f. Other (please specify)
        - _____
    g. Prefer not to answer
6. What professional behavioral health identity do you identify with?
    a. Clinical Mental Health Counseling
    b. Clinical Psychology
    c. Clinical Social Work
    d. Marriage and Family Therapy
    e. Other (please specify)
        - _____
7. Please indicate which of the following describes your current professional standing.
    a. Currently a masters-level student in a behavioral health training program
    b. Currently a doctoral-level student in a behavioral health training program
    c. Currently a post-graduate student accruing clinical hours and receiving supervision towards licensure no more than 6-months after graduation
8. How many months have you been providing direct clinical services to clients/patients in Integrated Primary Care settings?
    a. _____
9. How many months have you been receiving clinical supervision while practicing in an Integrated Primary Care setting?
    a. _____
10. Have your clinical supervisor(s) in an Integrated Primary Care setting been of the same professional identity as you?
    a. Yes
    b. No (please indicate your supervisor's professional identity)
        - _____
11. What model of behavioral health integration in primary care do you utilize and receive supervision for?

    a. Primary Care Behavioral Health (PCBH)
    b. Collaborative Care Model (CoCM)
    c. Other (please specify)
        - _____
    d. Unsure
12. Have you completed specialized coursework on Integrated Primary Care or Integrated Behavioral Health?
    a. Yes
    b. No
13. If yes, please indicate how many and what the courses were.
    a. _____
14. Have you completed training on clinical supervision?
    a. Yes
    b. No
15. If yes, please indicate how many and what the courses were.
    a. _____

--

In this section, you will be provided with 50 text entry spaces to indicate your perceptions of your supervisory needs as a novice behavioral health clinician in an Integrated Primary Care setting. For each unique supervisory need, please use a separate text entry space.

You are *not* required to use all 50 text entry spaces.

1. Based on your experience as a clinician in an Integrated Primary Care setting, what do new behavioral health clinicians need in supervision to enhance their practice in Integrated Primary Care?
   Please indicate as many statements as you can think of within various domains. ***These domains may include but are not limited to*** specific needs in knowledge, clinical skills, nonclinical skills, professional development, personal development, the supervisory relationship, etc.
   Examples of what statements ***could*** look like include: "A supervisor who is..." or "Information about..."
   Feel free to use language and structure that makes the most sense for you and highlights your perception of the supervisory needs of novice behavioral health clinicians in Integrated Primary Care settings.

APPENDIX D

ROUND 1 RESPONSES

P1

01-1. Supervisor availability to ask questions outside of scheduled supervision (on the fly supervision)
01-2. Flexibility in supervision structure (allowing for issues outside of direct patient care to come up)
01-3. Openness to feedback about changes that could enhance supervision experience
01-4. Mentorship about building relationships with other disciplines we work with,
01-5. Possibly more insight or ability to educate in supervision about medications or health conditions
01-6. Knowledge about logistics of clinic flow/other disciplines flow and how behavioral health fits into this,
01-114. Ability to give constructive feedback
01-7. A supervisor who provides opportunities to shadow their patient care and interactions with other providers,
01-8. A supervisor with broad expertise/generalist knowledge,
01-9. A supervisor who is open and honest about their adaption to integrated work and the difficulties involved at times

P2

02-10. Differentiating between typical therapy practices and behavioral health consultant work
02-11. General psychical health / medical knowledge or terminology
02- 12. Information about medications
02- 13. Motivational interviewing skills
02- 14. Somatic symptoms related to behavioral health concerns
02- 15. Nonjudgmental supervisor
02-16. supportive clinical staff / team
02-17. receptive supervision
02-18. flexible supervision
02- 19. how to collaborate with medical physicians better

P3

03- 20. Ego's to be checked at the door.
03- 21. Acknowledging the work the BHC is doing that may be positive/good.
03- 22. Addressing area where the BHC can improve/grow.
03- 23. Allowing space for the BHC to be critical without taking the criticism as a personal attack.
03- 24. Trust
03- 25. Understanding that their supervision is operating from good and supportive intent.
03- 26. Open and direct communication.
03- 27. Room to develop relevant skills like documentation, therapy techniques, etc.
03- 28. Guidance and mentorship.
03- 29. Professional growth opportunities
03- 30. A supervisor who is aware of the potential power dynamic at play and is not afraid to address it.

P4

04-31. ethical training
04-32. multicultural competency
04-33. career advancement opportunities outside of licensure

P5

05-34. A supervisor who is available.
05-35. A supervisor who is approachable.
05-36. A supervisor who is open to feedback.
05-37. A supervisor who is willing to be flexible.
05-38. Information about the patient population being served.
05-39. Information about the clinic work.
05-40. Information about the EHR system.
05-41. Information about professional development opportunities
05-42. A supervisor who is personable
05-43. A supervisor who is able to advocate for my needs as a new clinician
05-44. A supervisor that provides constructive feedback

P6
06-45. guidance on consultation services
06- 46. integrating self within interdisciplinary team
06- 47. information about common medical conditions
06- 48. treatment of loss and grief
06- 49. a supervisor who is a team player & emphasizes collaboration

P7
07-50. Information about Primary Care and/or Family Medicine practices
07-51. Information about the Medical Model
07-52. Information about how Behavioral Health is integrated into the setting/clinic
07-53. Information about how to interact with the Medical providers
07-54. Information about where to meet with patients (e.g., exam rooms, offices, etc)
07-55. Information about how to offer Behavioral Health services to patients (e.g., warm handoffs, during/separate from medical appointment)
07-56. Information about how to interact with Medical patients (e.g., how to introduce self, engage patients, etc)
07-57. Information about how to practice if Supervisor is out of office (e.g., go to Attending Physician if a patient has significant risk or discloses abuse)
07-58. Information about who to seek if patient needs Psychiatric consultation
07-59. Information about if/how to educate Medical providers on Behavioral Health concepts
07-60. Information about how to meet the patient where they are with their symptoms and presentations
07-61. A Supervisor who advocates for the Behavioral Health team
07-62. A Supervisor who has an open-door policy (e.g., if BHC needs support with a patient who has risk)
07-63. A Supervisor who plans adequate time for contractual supervisory requirements (e.g., 1 hour of supervision per week)
07-64. A Supervisor who offers opportunities to learn about Integrated Care practices
07-65. A Supervisor who offers opportunities to learn about evidence-based treatments (e.g., CBT for Chronic Pain, CBT for Insomnia)
07-66. A Supervisor who offers opportunities for BHCs to shadow Supervisor in their sessions and encounters
07-67. A Supervisor who helps guide the BHC towards professional growth and development
07-68. A Supervisor who continually evaluates BHC for their professional growth and development

P8
08-69. Community resources
08-70. Knowledge of clinic procedures
08-71. Well versed in Risk assessment

08-72. An understanding of the population
08-73. Collaborative
08-74. Systems focused
08- 75. Open
08- 76. Multicultural sensitivity

P9
09-77. A supervisor who provides guidance while also allowing enough independence for the training clinician to learn.
09-78. Information about different medications and health conditions that can affect mental health.
09-79. Monthly collaboration with physicians to discuss certain patients that are struggling.
09-80. Attending sessions where the supervisor observes the clinician in training for 15-20 min per session (like a resident model).
09-81. Physicians that understand the types of patients we can see and how to best use behavioral health providers.
09-82. Training in how to write factual and concise session notes.
09-83. Group supervision with other clinicians in training to feel supported.
09-84. Trainings in specific theoretical frameworks that are common in IBH settings (CBT, ACT, MI, etc.)
09-85. Trainings in common health conditions that are intertwined with mental health symptoms (chronic pain, insomnia)

P10
10-86. A supervisor who is flexible and able to adjust to supervisees needs
10-87. Information about interventions and models and how to apply them to primary care settings
10-88. How to work with multiple specialties
10-89. The role of bhc in the health system
10-90. Ongoing support from supervisors to supervise
10-91. Shadowing experience both to core BHC and to other specialties
10-92. Ongoing discussions about most common medical diagnosis

P11
P11-93. A supervisor who is readily available
P11-94. A supervisor who values supervision
P11-95. A supervisor who is willing to teach
P11-96. Information about medical issues
P11-97. Information about primary care culture
P11-98. Information about specific clinic culture & dynamics
P11-99. A supervisor trained in the biopsychosocial model
P11-100. A supervisor trained in motivational interviewing
P11-101. A supervisor who is able to conceptualize eclectically
P11-102. A supervisor who can fully explain PCBHi
P11- 103. A supervisor who can fully explain warm-handoffs within the clinic
P11-104. A supervisor who can directly observe clinical work
P11-105. A supervisor who wants to discuss a supervisee's career goals
P11-106. A supervisor who encourages supervisees to seek out career goals
P11-107. A supervisor who can listen and engage with supervisee's insecurities (i.e., imposter syndrome)

P12
12-108. A supervisor who is available.
12-109. Dedicated individual supervision.

12-110. Dedicated Group supervision with other integrated care clinicians/grads.
12-111. Orientation to role and proper training.
12-112. Basic understanding of differing roles/programs coming into integrated care setting.
12-113. Provides opportunities for professional development and critique for growth.

APPENDIX E

ROUND 2 QUESTIONNAIRE

1. Thank you for your participation in Round 2 of this Integrated Primary Care Supervision Delphi study!

   Your time and expertise is much appreciated. In this round, you will respond to a series of statements related to the supervisory needs of novice behavioral health clinicians in integrated primary care settings.

   This will be done by indicating your level of agreement to each statement. For statements that you do not agree with, you will have the opportunity to comment on ways to modify the statement or whether it should be removed. We encourage you to be wholly transparent regarding your agreement with these statements, as your responses are anonymous from other participants and researchers engaging in data analysis. By voicing agreement ***and*** disagreement with these statements, we are able to better understand the supervisory needs of novice behavioral health clinicians in integrated primary care settings.

   All statements have been created using responses generated by yourself and other Delphi panelists during Round 1.

   In Round 1, you and your fellow panelists generated a total of 114 statements about the supervisory needs of novice behavioral health clinicians in integrated primary care settings. During data analysis, we used your language to generate 65 distinct statements. Your participation in this round of the study is voluntary and can be rescinded at any time.

   Participation in this round will take approximately 25-40 minutes and is required to be eligible for compensation at the conclusion of Round 3. Do you agree to participate in this round of the study?
   a. I agree
   b. I disagree

--

2. Please indicate the best email to contact you for the third and final round of this study.
   a. _____

--

In this section, please indicate your level of agreement with the following statements related to the supervisory needs of novice behavioral health clinicians in integrated primary care settings.

The question that was asked during Round 1 was as follows: "***Based on your experience as a***

clinician in an Integrated Primary Care setting, what do new behavioral health clinicians need in supervision to enhance their practice in Integrated Primary Care?"

If you do not moderately or strongly agree with the statement, please provide us with suggestions on how to modify the statement, which may include but is not limited to modifications related to language or context, or whether to remove the statement entirely.

3. A supervisor who is flexible and readily available to provide receptive supervision (e.g., on the fly supervision, allowing for issues outside of direct patient care to come up, support for supervisee with a patient who has risk).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
2. A supervisor that provides constructive feedback (e.g., where the supervisee can improve and/or grow).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
3. A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model) and interactions with other providers.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____

4. A supervisor who offers opportunities for Behavioral Health Consultants (BHCs) to shadow the supervisor in their sessions and encounters (e.g., with core BHC and other specialties).
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
5. Egos to be checked at the door.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
6. Acknowledging the work the Behavioral Health Consultant (BHC) is doing that may be positive and/or good.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)

- _____

d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____

7. Allowing space for the Behavioral Health Consultant (BHC) to be critical without taking the criticism as a personal attack.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
8. Trust.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
9. Understanding that supervision is operating from a good and supportive intent.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)

- _____

d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____

10. Open and direct communication.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
11. A supervisor who provides guidance and mentorship while also allowing enough independence for the training clinician to learn.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
12. A supervisor who advocates for the behavioral health team, including the supervisee's needs as a new clinician.
    a. Strongly Agree
    b. Moderately Agree

c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

13. Information about how to practice if the supervisor is out of the office (e.g., go to an Attending Physician if a patient has significant risk opr discloses abuse).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
14. A supervisor who dedicates adequate time for contractual supervisory requirements (e.g., 1 hour of supervision per week, individual supervision, group supervision with other integrated care clinicians/grads).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
15. A supervisor who wants to discuss and encourages the supervisee's career goals.

a. Strongly Agree
b. Moderately Agree
c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

16. A supervisor who can listen and engage with the supervisee's insecurities (e.g., imposter syndrome).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
17. Orientation to role.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

18. A supervisor who continually evaluates the Behavioral Health Consultant (BHC) for their professional growth and development.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
19. A supervisor who is open to feedback about changes that could enhance the supervision experience.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
20. A supervisor who is open and honest about their adaptation to integrated work and the difficulties involved at times.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

21. A supervisor who is nonjudgemental.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
22. A supervisor who is aware of the potential power dynamics at play and is not afraid to address it.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
23. A supervisor who is approachable and personable.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

24. A supervisor who is willing to be flexible and able to adjust to supervisees' needs.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
25. A supervisor who is a team player and emphasizes collaboration.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
26. A supervisor who values supervision.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____

27. A supervisor who is willing to teach.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
28. A supervisor who is trained in the biopsychosocial model.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
29. A supervisor who is able to conceptualize eclectically.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

30. A supervisor trained in Motivational Interviewing (MI).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
31. A supervisor who can fully explain Primary Care Behavioral Health (PCBH).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
32. A supervisor who can fully explain warm-handoffs within the clinic.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

33. A supervisor with broad expertise and generalist knowledge.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
34. Mentorship about building relationships with other disciplines behavioral health clinicians work with.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
35. Information about how to integrate and collaborate with interdisciplinary teams and medical providers of multiple specialties.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)

- _____

f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)

- _____

36. Information about if and/or how to educate medical providers on behavioral health concepts.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
37. Monthly collaboration with physicians to discuss certain patients that are struggling.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
38. Information and ongoing discussion about medical knowledge and terminology, physical health, medical issues, and common medical conditions.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____

39. Information about medications.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
40. Information about somatic symptoms related to behavioral health concerns.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
41. Information about Primary Care and/or Family Medicine practices.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____

e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

42. Information about primary care culture.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
43. Information about the medical model.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
44. Information about who to seek if a patient needs psychiatric consultation.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

45. Information and trainings about common health conditions (e.g., chronic pain, insomnia) and medications that are intertwined with and affect mental health.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
46. A basic understanding of differing roles and/or programs when coming into integrated care settings.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
47. Information and knowledge about clinic procedures, logistical flow (e.g., other disciplines flow), and how behavioral health integration fits into the clinic (e.g., role of the Behavioral Health Consultant).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____

   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____

48. Information and understanding about the patient population being served.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____

49. Information about the Electronic Health Record system.
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____
   f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
      - _____

50. Information and guidance on how to offer behavioral health consultations and services (e.g., warm handoffs, during vs. separate from medical appointment) and where to meet with patients (e.g., exam rooms, separate offices).
   a. Strongly Agree
   b. Moderately Agree
   c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)

- _____

d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
   - _____

51. A supervisor who offers opportunities to learn about integrated care practices.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
52. Information about specific clinic culture and dynamics.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____
53. Differentiation between typical therapy practices and behavioral health consultant work.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
       - _____

d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

54. A supervisor who offers trainings and opportunities to learn and apply evidence-based treatments that are common in primary care settings, such as Cognitive Behavior Therapy (CBT; e.g., CBT for Chronic Pain, CBT for Insomnia), Motivational Interviewing (MI), and Acceptance & Commitment Therapy (ACT).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
55. Training and room to develop relevant skills, such as writing factual and concise documentation (e.g., session notes) and therapy techniques.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
56. Training on the treatment of loss and grief.
    a. Strongly Agree
    b. Moderately Agree

c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

57. Information about how to meet the patient where they are with their symptoms and presentations, and how to interact with them (e.g., how to introduce self, engage patients).
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
58. Being well-versed in risk assessment.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
59. Provision of opportunities for career and professional advancement (e.g., career advancement opportunities outside of licensure, critiques for growth).

a. Strongly Agree
b. Moderately Agree
c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

60. Information about professional development opportunities.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
61. A supervisor who helps guide the Behavioral Health Consultant (BHC) towards professional growth and development.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
62. Ethical training.

a. Strongly Agree
b. Moderately Agree
c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

63. Multicultural competency and sensitivity.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
64. Community resources.
    a. Strongly Agree
    b. Moderately Agree
    c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
    f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
        - _____
65. Ongoing support from supervisors to supervise.
    a. Strongly Agree

b. Moderately Agree
c. Slightly Agree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
d. Slightly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
e. Moderately Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____
f. Strongly Disagree (please indicate suggested changes to this statement as applicable, including whether this should be removed as a statement)
    - _____

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Please use this space to indicate any supervision needs of novice behavioral health clinicians in integrated primary care settings that were not represented in the statements above.

You are ***not*** required to add additional statements.

APPENDIX F

ROUND 2 RESULTS

Items Achieving Consensus After Round 2

Statement	Mdn	IQR
Supervisory Experience		
A supervisor that provides constructive feedback (e.g., where the supervisee can improve and/or grow).	1.00	0.00
A supervisor who offers opportunities for Behavioral Health Consultants (BHCs) to shadow the supervisor in their sessions and encounters (e.g., with core BHC and other specialties).	1.00	0.00
A supervisor who provides guidance and mentorship while also allowing enough independence for the training clinician to learn.	1.00	0.00
A supervisor who advocates for the behavioral health team, including the supervisee's needs as a new clinician.	1.00	0.00
A supervisor who dedicates adequate time for contractual supervisory requirements (e.g., 1 hour of supervision per week, individual supervision, group supervision with other integrated care clinicians/grads).	1.00	0.00
A supervisor who is flexible and readily available to provide receptive supervision (e.g., on the fly supervision, allowing for issues outside of direct patient care to come up, support for supervisee with a patient who has risk).	1.00	1.00
Acknowledging the work the Behavioral Health Consultant (BHC) is doing that may be positive and/or good.	1.00	1.00
Allowing space for the Behavioral Health Consultant (BHC) to be critical without taking the criticism as a personal attack.	1.00	1.00
Trust.	1.00	1.00
Open and direct communication.	1.00	1.00
Information about how to practice if the supervisor is out of the office (e.g., go to an Attending Physician if a patient has significant risk or discloses abuse).	1.00	1.00
Egos to be checked at the door.	1.50	1.00
Understanding that supervision is operating from a good and supportive intent.	1.50	1.00
A supervisor who can listen and engage with the supervisee's insecurities (e.g., imposter syndrome).	1.50	1.00
Supervisor Characteristics		
A supervisor who is aware of the potential power dynamics at play and is not afraid to address it.	1.00	0.00
A supervisor who is a team player and emphasizes collaboration.	1.00	0.00
A supervisor who is open to feedback about changes that could enhance the supervision experience.	1.00	1.00
A supervisor who is open and honest about their adaptation to integrated work and the difficulties involved at times.	1.00	1.00
A supervisor who is nonjudgmental.	1.00	1.00
A supervisor who is approachable and personable.	1.00	1.00
A supervisor who is willing to be flexible and able to adjust to supervisees' needs.	1.00	1.00

Statement	Mdn	IQR
A supervisor who is willing to teach.	1.00	1.00
A supervisor who values supervision.	1.50	1.00
Supervisor Knowledge & Training		
A supervisor who can fully explain Primary Care Behavioral Health (PCBH).	1.00	1.00
A supervisor with broad expertise and generalist knowledge.	1.00	1.00
Interdisciplinary Training		
Information about if and/or how to educate medical providers on behavioral health concepts.	1.00	0.00
Mentorship about building relationships with other disciplines behavioral health clinicians work with.	1.00	1.00
Information about how to integrate and collaborate with interdisciplinary teams and medical providers of multiple specialties.	1.00	1.00
Medical Training		
Information about somatic symptoms related to behavioral health concerns.	1.00	1.00
Information about who to seek if a patient needs psychiatric consultation.	1.00	1.00
Information and trainings about common health conditions (e.g., chronic pain, insomnia) and medications that are intertwined with and affect mental health.	1.00	1.00
A basic understanding of differing roles and/or programs when coming into integrated care settings.	1.00	1.00
Information about Primary Care and/or Family Medicine practices.	1.50	1.00
Information and ongoing discussion about medical knowledge and terminology, physical health, medical issues, and common medical conditions.	2.00	1.00
Information about primary care culture.	2.00	1.00
Information about the medical model.	2.00	1.00
Clinic-Specific Orientation		
Information and knowledge about clinic procedures, logistical flow (e.g., other disciplines flow), and how behavioral health integration fits into the clinic (e.g., role of the Behavioral Health Consultant).	1.00	1.00
Information and understanding about the patient population being served.	1.00	1.00
Information about the Electronic Health Record system.	1.00	1.00
Information and guidance on how to offer behavioral health consultations and services (e.g., warm handoffs, during vs. separate from medical appointment) and where to meet with patients (e.g., exam rooms, separate offices).	1.00	1.00
A supervisor who offers opportunities to learn about integrated care practices.	1.00	1.00
Information about specific clinic culture and dynamics.	2.00	1.00
Clinical Training		
Differentiation between typical therapy practices and behavioral health consultant work.	1.00	1.00
A supervisor who offers trainings and opportunities to learn and apply evidence-based treatments that are common in primary care settings, such as Cognitive Behavior Therapy (CBT; e.g., CBT for Chronic Pain, CBT for Insomnia), Motivational Interviewing (MI), and Acceptance & Commitment Therapy (ACT).	1.00	1.00

Statement	Mdn	IQR
Training and room to develop relevant skills, such as writing factual and concise documentation (e.g., session notes) and therapy techniques.	1.00	1.00
Being well-versed in risk assessment.	1.00	1.00
Information about how to meet the patient where they are with their symptoms and presentations, and how to interact with them (e.g., how to introduce self, engage patients).	2.00	1.00
Professional Development		
Provision of opportunities for career and professional advancement (e.g., career advancement opportunities outside of licensure, critiques for growth).	1.00	1.00
A supervisor who helps guide the Behavioral Health Consultant (BHC) towards professional growth and development.	1.00	1.00
Information about professional development opportunities.	2.00	1.00
Additional Supervisory Needs		
Multicultural competency and sensitivity.	1.00	0.00
Ongoing support from supervisors to supervise.	1.00	1.00
Ethical training.	1.50	1.00
Community resources.	1.50	1.00

Mdn – median; IQR – interquartile range

Items Not Achieving Consensus After Round 2

Statement	Mdn	IQR
Supervisory Experience		
A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model) and interactions with other providers.	2.00	2.00
A supervisor who wants to discuss and encourages the supervisee's career goals.	1.00	2.00
Orientation to role.	1.50	2.00
A supervisor who continually evaluates the Behavioral Health Consultant (BHC) for their professional growth and development.	1.00	2.00
Supervisor Training & Knowledge		
A supervisor who is trained in the biopsychosocial model.	2.50	3.00
A supervisor who is able to conceptualize eclectically.	2.00	2.00
A supervisor trained in Motivational Interviewing (MI)	2.00	2.00
A supervisor who can fully explain warm-handoffs within the clinic.	1.50	2.00
Interdisciplinary Training		
Monthly collaboration with physicians to discuss certain patients that are struggling.	2.00	2.00
Medical Training		
Information about medications.	2.00	2.00
Clinical Training		
Training on the treatment of grief and loss.	2.00	2.00

Mdn – median; IQR – interquartile range

Feedback for Items Not Achieving Consensus

1. ***A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model) and interactions with other providers.***
    i. Can Frequency be included. (E.g. once every 3 months, twice a year)
    ii. In the parentheses, add 'listening to a recorded session'
    iii. This varies for me based on the frequency that this happens. I don't think there always needs to be direct shadowing but a few times throughhout the trimester/semester could be very useful.

2. ***A supervisor who wants to discuss and encourages the supervisee's career goals.***
    i. This would be a nice bonus but not an essential for me.
    ii. This is a nice addition to supervisor, but I don't think would need to be a baseline requirement.
    iii. Again, this is not necessary for a supervisor and could be fulfilled by the mentor. This could also be problematic if the supervisee feels pressured to stay in the training setting they're in.

3. ***Orientation to role***
    i. If the supervisor in unable to do this, making sure there are other staff/clinicians available to do this
    ii. describe further
    iii. I think this statement needs more clarification. It's a little vague.
    iv. Eliminate

4. ***A supervisor who continually evaluates the Behavioral Health Consultant (BHC) for their professional growth and development.***
    i. I would not want this to be the focus of my supervisor.
    ii. I feel the supervision should be more guidance and learning than evaluation which feels very performative and stressful.
    iii. Confused don't know what this means. Eliminate

5. ***A supervisor who is trained in the biopsychosocial model.***
    i. Formal training not required; Enough experience working in integrated setting and ability to discuss the biopsychosocial model
    ii. Dependent upon what one hopes to learn. A strong understanding is important though.
    iii. I agree but also a supervisor who is trained in the biomedical model and understand the model under which other healthcare team members practice.
    iv. more integrated and collaborative models
    v. I do not see that as a baseline need for supervision. I feel this would depend on the BHC setting and population.

6. ***A supervisor who is able to conceptualize eclectically.***
    i. If not able to conceptualize eclectically, able to direct supervisee to appropriate help elsewhere (i.e., other clinicians or staff members)

ii. They just need to have an understanding of the value bhcs bring and listen to how a bhc is viewing a client. A supervisor can conceptualize with whichever theory they want as long as they are open-minded
iii. I don't really know what this means; the statement could me more simple and clear as it is to vague the way it currently reads.

7. A supervisor trained in Motivational Interviewing (MI).
i. Formal training not required but general understanding of concepts or willing to research with supervisee
ii. do not agree that supervisor must be trained in a specific modality to be a good supervisor
iii. Eliminate

8. A supervisor who can fully explain warm-handoffs within the clinic.
i. I think some of this is on the student to adapt/learn.
ii. Fully explain what about warm handoffs? How they function within the specific clinic, how to approach them clinically? I think it's important but don't fully understand the meaning of the statement
iii. I don't think this needs to happen in order to have good supervision, although it is helpful if it does.

9. Information about medications.
i. Important insight for understanding, but counselors don't prescribe so less important than other topics listed.
ii. Again, we are not prescribers and this is not a role I expect my supervisor to fill well.
iii. Medications are within the scope of physicians. Though it is beneficial for BHC clinicians to know a bit about medications commonly used at their practice site, I don't believe it should be a requirement.

10. Monthly collaboration with physicians to discuss certain patients that are struggling.
i. Formal collaboration not necessary, but some way to communicate (can be via EMR or informal communication)
ii. I think this would only be needed if the placement was in an integrated setting, otherwise it may not be needed if there is not ongoing communication between different specialties.
iii. Eliminate

11. Training on the treatment of loss and grief.
i. I would refer out to outpatient for this
ii. This is oddly specific and your supervisor may not be able to do this.

New Statements Created by Expert Panelists

1. ***Creating a psychologically safe space for the BHC to receive supervision.***
2. ***Addressing power dynamics and other 'isms' that could potentially come up in supervision.***

APPENDIX G

ROUND 3 QUESTIONNAIRE

1. Thank you for your participation in Round 3 of this Integrated Primary Care Supervision Delphi study! This is the final round of this study, so we thank you for your time and expertise as we have explored this topic to understand the supervisory needs of novice behavioral health clinicians in integrated primary care settings.

   In this round, you will indicate your level of agreement to a series of statements that did not reach consensus during Round 2 and were amended and/or added based on feedback provided by you and your expert peers.

   At the conclusion of this study, you will have the opportunity to review the statements that received consensus during Round 2 and provide the researchers with your email to receive financial compensation.

   Your participation in this round of the study is voluntary and can be rescinded at any time. Participation in this round will take approximately 10-20 minutes. Do you agree to participate in the final round of the study?
   a. I agree
   b. I disagree

--

In this section, please indicate your level of agreement to the following amended statements regarding the supervisory needs of novice behavioral health clinicians in integrated primary care settings that did not achieve statistical consensus during Round 2.

2. A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model, listening to a recorded session) and interactions with other providers a few times throughout training (e.g., once every 3 months, twice a year, few times through the trimester/semester).
   a. Strongly Agree
   b. Moderately Agree
   c. Somewhat Agree
   d. Somewhat Disagree
   e. Moderately Disagree
   f. Strongly Disagree

3. A supervisor who is open to discussing and encouraging the supervisee's career goals.
   a. Strongly Agree
   b. Moderately Agree
   c. Somewhat Agree
   d. Somewhat Disagree
   e. Moderately Disagree
   f. Strongly Disagree

4. Orientation to the supervisee's role in primary care by the supervisor and, if needed, the supervisor making sure there are other staff/clinicians available to do this.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

5. A supervisor who provides evaluation and learning opportunities for the Behavioral Health Consultant's (BHC's) professional growth and development.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

6. A supervisor who has experience working in integrated settings.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

7. A supervisor who has a strong understanding of the biopsychosocial model and models used by other healthcare team members (e.g., biomedical model, integrated and collaborative models).
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

8. A supervisor who can conceptualize eclectically and/or connect to resources for conceptualization.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

9. A supervisor who is able to open-mindedly understand the values that Behavioral Health Consultants (BHCs) bring and listen to how they are conceptualizing a client.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

10. A supervisor with an understanding of modalities common in primary care (e.g., Motivational Interviewing).
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

11. A supervisor who is willing to research with the supervisee.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

12. A supervisor who can fully explain warm handoffs within the clinic (e.g., how they function in the clinic, how to approach them clinically).
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

13. An understanding of medications within the scope of the Behavioral Health Consultant (BHC), including common medications prescribed at the site.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

14. Formal (e.g., monthly meeting) and informal (e.g., communicate via Electronic Medical Record) collaboration with physicians to discuss certain patients that are struggling.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

15. Training on the treatment of loss and grief (e.g., when to refer to outpatient).
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

16. Creating a psychologically safe space for the BHC to receive supervision.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

17. Addressing power dynamics and other 'isms' that could potentially come up in supervision.
    a. Strongly Agree
    b. Moderately Agree
    c. Somewhat Agree
    d. Somewhat Disagree
    e. Moderately Disagree
    f. Strongly Disagree

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Please indicate the best email for you to receive your $50 Amazon eGift Card.

Compensation will be distributed ASAP, with compensation being sent to you by 5pm on February 14th ***at the latest***.

--

During Round 2, items were indicated to have reached consensus if the descriptive statistics indicated a Median (Mdn) of 1 or 2 (Strongly Agree or Moderately Agree) and an Interquartile Range (IQR) of 1.00 or less.
Here is the list of supervisory needs of novice behavioral health clinicians in integrated primary care settings that reached consensus during Round 2.

Please do not distribute or use this data at the present moment.

APPENDIX H

ROUND 3 RESULTS

Items Achieving Consensus After Round 3

Statement	Mdn	IQR
Supervisory Experience		
Creating a psychologically safe space for the BHC to receive supervision.	1.00	0.00
Addressing power dynamics and other 'isms' that could potentially come up in supervision.	1.00	1.00
A supervisor who provides evaluation and learning opportunities for the Behavioral Health Consultant's (BHC's) professional growth and development.	1.00	1.00
A supervisor who can attend and directly observe clinical work (e.g., shadowing for 15-20 minutes like a resident model, listening to a recorded session) and interactions with other providers a few times throughout training (e.g., once every 3 months, twice a year, few times through the trimester/semester).	1.50	1.00
Orientation to the supervisee's role in primary care by the supervisor and, if needed, the supervisor making sure there are other staff/clinicians available to do this.	2.00	1.00
Supervisor Characteristics		
A supervisor who is open to discussing and encouraging the supervisee's career goals.	1.00	1.00
A supervisor who is able to open-mindedly understand the values that Behavioral Health Consultants (BHCs) bring and listen to how they are conceptualizing a client.	1.00	1.00
Supervisor Training & Knowledge		
A supervisor who has experience working in integrated settings.	1.00	1.00
A supervisor with an understanding of modalities common in primary care (e.g., Motivational Interviewing).	1.00	1.00
A supervisor who has a strong understanding of the biopsychosocial model and models used by other healthcare team members (e.g., biomedical model, integrated and collaborative models).	2.00	1.00
Clinic-Specific Orientation		
A supervisor who can fully explain warm handoffs within the clinic (e.g., how they function in the clinic, how to approach them clinically).	1.50	1.00
Medical Training		
An understanding of medications within the scope of the Behavioral Health Consultant (BHC), including common medications prescribed at the site.	2.00	1.00

Statement	Mdn	IQR
Interdisciplinary Training		
Formal (e.g., monthly meeting) and informal (e.g., communicate via Electronic Medical Record) collaboration with physicians to discuss certain patients that are struggling.	2.00	1.00
Clinical Training		
Training on the treatment of loss and grief (e.g., when to refer to outpatient).	2.00	1.00

Mdn – median; IQR – interquartile range

Items Not Achieving Consensus After Round 3

Statement	Mdn	IQR
Supervisor Training & Knowledge		
A supervisor who can conceptualize eclectically and/or connect to resources for conceptualization.	2.00	2.00
A supervisor who is willing to research with the supervisee.	3.00	1.00

Mdn – median; IQR – interquartile range

VITA

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EDUCATION

2024 Ph.D. in Education – Counseling, Old Dominion University

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PROFESSIONAL EXPERIENCE

2024-Now Assistant Professor, Philadelphia College of Osteopathic Medicine

2023-2024 Doctoral Mental Health Counseling Intern – Primary Care, Chesapeake Regional Healthcare

2021-2023 Graduate Assistant – Research, Teaching, Administrative, and Admissions, Old Dominion University

PUBLICATIONS

Schmoyer, N., & Carlisle, K. (2023). “Teamwork makes the dream work”: Infusing interprofessional education into human services curriculum and training. *Journal of Human Services*, *42*(1), 22-36. https://doi.org/10.52678/001c.74213

Schmoyer, N., Corbin, L., & Robins, L. (2023). Integrated behavioral health training in counselor education: A call to action. *Journal of Integrated Primary Care*, *1*(1), 1.