

Health care is experiencing an advancement in which systems are moving away from fragmented services to models of integrated care (Blount, 2003). Since Engel's (1977) introduction of the biopsychosocial model, the need for integration, collaboration, and effective communication has been at the forefront of health care. Engel proposed that the existing biomedical model was incomprehensive, and that providing holistic care should include the individual's biological, psychological, social, emotional, and behavioral factors.

Without integrated care services, prevalent mental health issues in diverse populations go untreated. Research shows that about 15%–21% of children between ages 6–17 have mental health issues, but only about 20% receive care (Kataoka, Zhang, & Wells, 2002). Additionally, the Center for Disease Control and Prevention (CDC, 2014) reported that about 25% of all adults in the United States have mental illness, and approximately 50% of adults will develop at least one mental illness in their lifetime. However, an estimated 50%–70% of people seek mental health related treatment in primary care settings (Gatchel & Oordt, 2003). These may be related to co-existing physical and mental illnesses (Allen, Balfour, Bell, & Marmot, 2014), mental health stigma (Gary, 2005), and financial and economic issues (Calouste Gulbenkian Foundation, 2014 & World Health Organization [WHO]). Although a “one-stop” treatment modality is convenient, the concern remains that primary care practitioners alone may inefficiently treat consumers' mental or behavioral health needs because of inadequate preparation (Beacham, Herbst, Streitwieser, Scheu, & Sieber, 2012), time constraints (Fox, Hodgson, & Lamson, 2012), and uneasiness in addressing specific mental health cases (Pratt, DeBerard, Davis, & Wheeler, 2012). This remains one of several rationales for integrated care that provides opportunity for continuity, access, and efficiency of care.

Until recently, little to no collaboration occurred between primary care and mental health practitioners, leading to fragmented treatment services. Experts have argued that behavioral health training programs, such as graduate counseling programs, have a responsibility to train its workforce for this treatment modality (Edwards & Patterson, 2006; Johnson & Freeman, 2014). Studies show that counselors who have worked in integrated care settings have reported that this level of care is valuable, but they have also advocated for training (Gersh, 2008; Glueck, 2015). Without training, the disparities in the scope of practice, communication, and treatment modalities between counselors and medical health practitioners are illuminated (Hunter, Goodie, Oordt, & Dobmeyer, 2009; Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012).

Considering that there is a void in the literature regarding counselor training and competencies or perceived competencies in integrated care, this study explored graduate counseling students' perceived competencies to assess participants' knowledge, attitude, and skills about integrated care. Mainly due to the work of Albert Bandura (Bandura, 1977, 1986), evidence exists to support the assertion that one's self-efficacy is related to competence (Lunenburg, 2011). Thus, graduate counseling students' perception of their skills, knowledge, and attitude towards integrated care likely have influence on their engagement in integrated care employment opportunities. Essentially, the author of the current research was interested in what students believe they know or can accomplish as it pertains to integrated care. It is noteworthy that "behavioral health practitioners" used in the literature review is representative of counselors and other mental health practitioners. Sections that are specific to professional counseling or counselor education are indicated.

Related Literature Review

Integrated Care: Cultural Disparities and Challenges

The call for integrated care training in many instances has been driven by the cultural disparities that exist between the traditional medical and behavioral health professional training programs. Traditional medical practitioners trained to focus on the medical and physical needs of consumers may be biased toward treating only physical health, while behavioral health practitioners have a bias and are specialized to treat mental and behavioral health issues. The biases create clinical and operational challenges (Fox et al., 2012). These cultural disparities could relate to language differences, use of space and time, scope of practice, and privacy and confidentiality issues (Edwards & Patterson, 2006; Hunter et al., 2009; Vogel et al., 2012).

Primary care and behavioral health practitioners speak different professional languages and sometimes apply different treatment modalities (Edwards & Patterson, 2006). Although most health professionals are trained to understand the connection between biomedical and psychosocial needs, specialization makes it difficult for professionals to competently understand each other's practice. Originally, primary care practitioners offered support to consumers' with behavioral health issues; but, the introduction of "*miracle medicine*" as described by Robinson and Reiter (2007, p. 84), has gradually reduced the time spent with consumers. Treatment of choice is falling on more medication and less behavioral interventions. On the other hand, behavioral health practitioners exposed to a plethora of behavioral interventions become more apt to provide behavioral care than the medical components of the consumer's needs. Edwards and Patterson (2006) used the example of family therapists' usage of terms such as "parentification, enmeshment, and circular causality which [are] unfamiliar to medical care providers and coexist with another language, including myocardial infarction and irritable bowel syndrome" (p.35). In other words,

some mental health related issues can co-exist with physical health issues, but the language barrier may impede treatment efficacy. Moreover, language disparity becomes obvious when behavioral health practitioners refer to consumers as “clients” and primary care practitioners refer to them as “patients” (Edwards & Patterson, 2006, p. 35).

The use of time is among the most cited disparities between behavioral and primary care practitioners (Edwards & Patterson 2006; Hunter et al., 2009; Robinson & Reiter, 2007). Primary care practitioners typically spend 15 to 30 minutes with each patient, but traditional behavioral health practitioners spend between 50 minutes to an hour per client session. This creates challenges when behavioral health practitioners in integrated care settings are expected to adapt the 15-30 minute time-span. The issues involved in treatment time correlates with the clinical challenges (Fox et al., 2012). Treatment modalities for behavioral health in integrated care, as opposed to traditional mental health treatment, continue to seek brief treatments (Fox et al., 2012; Robinson & Reiter, 2007) with less emphasis on probes to unexpressed symptoms.

Further challenges are related to the use of space and assuring confidentiality. Usually, in a traditional counseling setting, a behavioral health practitioner’s office is without interruption. However, in an integrated care setting, privacy is not guaranteed. Ethical issues regarding confidentiality are heightened for behavioral health practitioners because “the unit of confidentiality in mental health is between the therapist and the consumer, whereas the unit of confidentiality in primary care, and in medicine generally, is between the consumer and the team” (Blount & Bailey, 2014, p. 2). This creates ethical dilemmas for behavioral health practitioners because their ethical responsibility to maintain client confidentiality might be blurred.

Another challenge worth noting relates to issues surrounding professional identity. In exploring counselor identity and its impact in integrated care environments, Gersh (2008)

interviewed six licensed professional counselors working in an integrated care environment. Results of the study indicated that counselors' expressed change in roles (from "a specialist" to a "generalist") and mode of operation which affect their identity. Garcia-Shelton and Vogel (2002) have suggested that strong professional identity is essential to effective functioning in integrated care settings. Therefore, exposure to integrated care training bridges the gap and promotes understanding of roles and responsibilities, reduces assumptions, and helps to create a conducive environment for practitioners (Beacham et al., 2012; Hoover & Andazola, 2012).

SAMHSA-HRSA's Efforts to Bridge the Gap

With a primary goal of bridging the gap, the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration (SAMHSA-HRSA) initiated the development of integrated care competency categories for health organizations and training programs (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). Hoge et al. explained that the standards were developed to satisfy the need for a common set of competencies in integrated care settings, and to provide guidance for the integration of behavioral health into primary care. The SAMHSA-HRSA competencies are categorized into nine sections and include: (a) interpersonal communications, (b) collaborations and teamwork, (c) screening and assessment, (d) care planning and care coordination, (e) intervention, (f) cultural competence and adaptation, (g) systems oriented practice, (h) practice-based learning and quality improvement, and (i) informatics (Hoge et al., 2014, p. 4). Each of these categories has competencies enumerated to suggest the specific best practices and potential expectations for medical and behavioral health practitioners. Employing the nine SAMHSA-HRSA competency categories as foundation, the researcher for this current study developed a survey instrument—Integrated Care Competency Survey (ICCS) —

used as the primary instrument for this study. Further information about the ICCS is provided in the instrumentation section of this article.

Additionally, the SAMHSA–HRSA Center for Integrated Health Solutions (CIHS) established and funded programs to promote the integration of primary and behavioral health services. SAMHSA-HRSA CIHS (n.d.) provides resources, including grants, to support integrative efforts and training initiatives. A few counselor education programs have applied for, and have received grants that enabled training of counselor trainees in integrated care centers (HRSA, 2014). These grants are an indication that both HRSA and some counseling programs place value on preparing graduate counseling students for integrated services.

The Focus of this Current Study

Support for integrated care from professional counseling organizations has increased. For example, the American Mental Health Counselors Association (AMHCA, 2016) has developed integrated care standards. Additionally, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) has a provision in its current standards that stipulates graduate counseling students' exposure to "multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation" (p. 8). However, professional counselors lack training in integrated care (Gersh, 2008), and there is a similar limitation in literature about graduate counseling students' training.

To promote education, access, and continuity of care for health consumers, counselor trainees need to be well-equipped and positioned to function in integrated care settings. Counselor education programs can ascertain aspects of the SAMHSA-HRSA competencies that need to be addressed in the existing CACREP curricula to bridge the necessary gaps. In this study, students'

perceived competencies of integrated care are assessed. Furthermore, students in counselor education programs awarded with a HRSA grant for integrated care initiatives, (a) identify acquired skills developed as a result of going through CACREP programs, (b) identify challenges faced when placed in integrated care settings for apprenticeship, and (c) indicate strategies they used to overcome the identified challenges.

Overall, the purpose of this study was twofold: (a) to quantitatively examine graduate counseling students' perceived competencies relative to the SAMHSA–HRSA integrated care competency categories, and (b) to qualitatively understand the experiences of students who have had field placements in integrated care sites. To achieve the purpose of the study, the following research questions were addressed: (a) to what extent do graduate counseling students perceive their level of competence based on the integrated care competency survey (ICCS)? (b) What are graduate counseling students experiences with integrated care?

Method

Participants

The participants ($n = 243$) constituted of graduate counseling students from 15 CACREP accredited programs across the United States, with specialties in addiction, clinical mental health, clinical rehabilitation, college, and marriage, couple and family counseling. The majority of the total sample were: master's degree students ($n = 225, 92.6\%$), clinical mental health specialty ($n = 187, 75.7\%$), females ($n = 211, 86.8\%$), and no training in integrated care ($n = 186, 76.5\%$). Participants with training in integrated care ($n = 57$) with non-mutually exclusive responses selected options such as coursework ($n = 45$), workshop ($n = 21$), conferences ($n = 19$), and certificate training ($n = 5$), as the mode of training in integrated care.

There were 129 (53.1%) participants with no field experience and 114 (46.9%) participants with field experience. Among those who have had field experience, 38 (33%) had placement in integrated care settings, and 76 (67%) had experiences in other field placements beside integrated care settings. The mean age for the participants was 30.24 years ($SD = 10.13$), with the youngest participant being 21 years and the oldest being 70 years.

Procedure

This study employed a survey research method, and was limited to graduate counseling students in CACREP accredited counselor education programs. Through a contact person from CACREP, 346 eligible programs were identified, and a total of 15 CACREP accredited counseling programs agreed to participate in the study. Six programs were purposefully selected because they were recipients of the HRSA grant for integrated care training (HRSA, 2014). The additional nine programs were randomly sampled from the remaining CACREP accredited programs. Following Institutional Review Board (IRB) approval, invitation emails containing the Web-based Qualtrics URL to the survey were distributed to the faculty contact persons in each of the participating programs. They in turn forwarded the invitation emails to their programs' listservs. Because confidentiality was promised, names and specific identifying information of participants or their programs will not be divulged in this article.

Instrumentation: Integrated Care Competency Survey (ICCS)

Information regarding students' perceived competency in integrated care was collected as part of a larger research study focused on counselor trainees' integrated care development, and the assessment of the ICCS. Although there were instruments that measured interprofessional education (Curran, Sharpe, Forristall, & Flynn, 2008; Parsell & Bligh, 1999), they were not targeted to competencies about integrated care. Consequently, the author for this current research

generated the ICCS items from the nine SAMHSA-HRSA integrated care competency categories (Hoge et al., 2014) because it served as the single most widely recognized set of competencies at the time of this study. At its initial development, the ICCS comprised of 95 competency items. According to DeVellis (2012), cognitive interviews, expert reviews, and a pilot study are appropriate steps to ensure content validity. As a result, four expert reviewers (two practitioners and two methodologists) provided feedback in revising the items. Additionally, in conducting cognitive interviews, four graduate counseling students were asked to read the survey items for readability, clarity, and conciseness. Subsequently, a pilot study was conducted with a total of 36 graduate counseling students as part of the validation process which yielded a total of 65 competency items on the nine competency categories for the ICCS. Furthermore, 11 demographic items and 3 open-ended questions were included to establish variables and students' experiences in integrated care respectively. The participants responded to the competency items using a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The 6-point Likert-scale was grouped into quartiles, with a median score of 3.5. A score of 5 and above was classified as strongly competent, 3.5 to 4.9 was competent, 2 to 3.4 moderately competent, and 1.9 and below was low competence. The overall Cronbach's alpha on the 65 competency items was .98.

Research Design and Analytic Strategies

Due to the exploratory nature of this study, a mixed method design with the purpose of expansion was employed. A mixed method expansion design is used when "extending the scope, breadth, and range of inquiry by using different methods for different inquiry components" (Greene, Caracelli, & Graham, 1989, p. 269). In essence, this type of design allows for a more comprehensive examination of the same paradigm but different methods and sets of questions are used to examine various phenomena. A quantitative method alone may be insufficient when

researchers are interested in understanding experiences of respondents (O’Cathain, Murphy, & Nicholl, 2007). Thus, in the context of examining graduate counseling students’ perspectives about integrated care, the ICCS items captured the overall perceptions of students but the qualitative open-ended questions were added to the survey items to understand the unique experiences of students who have had field experiences in these types of settings.

Data analysis for the quantitative section of the study was conducted using descriptive statistics on selected characteristics about graduate counseling students on the nine SAMHSA-HRSA competency categories. The researcher used the SPSS statistical software for the quantitative aspect of the analyses. Additionally, Braun and Clarke’s (2006) qualitative thematic analysis guidelines helped to establish codes and themes from participants’ responses to the three open-ended questions. The steps involved familiarity with the data, generation of initial codes, searching for themes, reviewing the themes, defining and naming themes, and writing the report. Furthermore, the researcher used qualitative bracketing measures such as involving two other analysts in the thematic process to increase trustworthiness. Each analyst examined the data, and over at least three meetings of iterative processes, the analysts were able to triangulate their findings to reach a consensus on the themes. According to Guba (1981), the use of additional evaluators increases qualitative trustworthiness, and it mitigates preconceived notions from qualitative researchers (Tufford & Newman, 2012).

Results

Quantitative Research Question

For research question 1, analyses focused on participants’ overall perceived competencies, the nine sub-categories, and on selected demographic characteristics. The overall mean for the ICCS was 3.95 ($SD = .83$) with a 95% confidence interval of [3.85, 4.06]. Based on the quartiles

previously defined for the ICCS scores, the participants overall mean score was described as competent. The minimum average score on the ICCS was 1.49 and a maximum average score was 5.57. Table 1 gives a summary of the descriptive statistics for the overall ICCS and the sub-categories.

Table 1

Descriptive Statistics for Overall ICCS and the Competency Categories

ICCS ^a	<i>M</i>	<i>Mdn</i>	<i>SD</i>	Min	Max	95% CI for mean
Overall	3.95	4.03	0.83	1.49	5.57	[3.85, 4.06]
SC 1	4.67	4.83	0.61	1.00	6.00	[4.57, 4.77]
SC 2	4.78	4.86	0.75	2.00	6.00	[4.69, 4.88]
SC3	4.09	4.25	1.00	1.00	6.00	[3.97, 4.22]
SC 4	3.62	3.75	1.04	1.00	6.00	[3.49, 3.75]
SC 5	3.87	4.00	1.06	1.10	6.00	[3.73, 4.00]
SC 6	4.35	4.50	0.93	1.33	6.00	[4.23, 4.46]
SC 7	3.30	3.33	1.06	1.00	6.00	[3.17, 3.44]
SC 8	3.66	3.75	0.94	1.00	5.75	[3.54, 3.78]
SC 9	3.32	3.17	1.18	1.00	6.00	[3.16, 3.46]

Note: ^a*n* = 243; CI = confidence interval; sub-category 1 (SC1) = interpersonal communication; sub-category 2 (SC2) = collaboration and teamwork; sub-category 3 (SC3) = screening and assessment; sub-category 4 (SC4) = care planning and care coordination; sub-category 5 (SC5) = intervention; sub-category 6 (SC6) = cultural competence and adaptation; sub-category 7 (SC7) = systems oriented practice; sub-category 8 (SC8) = practice-based and quality improvement; sub-category 9 (SC9) = informatics.

In addition, the descriptive statistics on the five main demographic groups (gender, graduate level, specialty, field experience, field placement, and exposure to training) were analyzed on the overall ICCS to understand how each demographic perceived their levels of competence in integrated care. For gender, the mean score for females was 3.96 (*SD* = .83) and that of the males was 3.93 (*SD* = .85). Table 2 provides information on the descriptive statistics for the rest of the selected demographic variables. Additional results indicate that participants

reported interest in working in integrated care settings. Of the total 243 students, the majority ($n = 224, 92.2\%$) were interested in working in integrated care environments.

Table 2

Descriptive Statistics on Demographics for Overall ICCS–Main Study

ICCS	<i>n</i>	<i>M</i>	<i>Mdn</i>	<i>SD</i>	95% CI for mean
Graduate Level ($n = 243$)					
Master's	225	3.91	3.98	.83	[3.80, 4.01]
Doctorate	18	4.54	4.45	.61	[4.24, 4.85]
Counseling Specialty ($n = 243$)					
Marriage, couple and family	24	3.90	3.88	.69	[3.61, 4.19]
Clinical mental health	184	4.00	4.13	.82	[3.89, 4.12]
Clinical rehabilitation	6	4.13	4.29	.55	[3.55, 4.71]
Addiction	7	4.17	3.92	.72	[3.51, 4.83]
College	22	3.46	3.55	1.02	[3.01, 3.91]
Field Experience ($n = 243$)					
Practicum	47	4.06	4.20	.79	[3.82, 4.29]
Internship	67	4.35	4.32	.57	[4.21, 4.48]
No field experience	129	3.71	3.82	.87	[3.56, 3.86]
Field Placement ($n = 114$)					
Integrated Care	38	4.52	4.49	.50	[4.35, 4.69]
Other	76	4.07	4.05	.71	[3.92, 4.24]
Training in integrated care ($n = 243$)					
Yes	57	4.58	4.54	.57	[4.43, 4.73]
No	186	3.76	3.86	.80	[3.65, 3.88]

Note: CI = confidence interval.

Qualitative Research Question

The researcher used three open-ended questions to answer research question 2. Responses were coded for themes for each of the questions as described in the next section.

Open-ended question 1. What did you find most challenging when you first started working in the integrated care environment? Thirty (30) participants' responses yielded three themes: Adjustment and adaptation, communication and collaboration, and lack of training.

Adjustment and adaptation challenges. This theme emerged as participants described difficulties including getting accustomed to new roles, use of brief treatment time, understanding medical models, and embracing professional identity. For instance, a participant stated: "adjusting to brief, behavioral interventions and supportive role, rather than full 50-minute sessions that focused on exploration of emotions..." Another participant indicated that "learning medical terminology...learning how to use integrated EMRs [Electronic Medical Records]" was a challenge.

Communication and collaborative challenges. Referring to language use, confidentiality, and flow of communication challenges, participants' stated the following: "breaking the barriers between agencies and speaking the same professional language;" and "ability to balance information that should be shared and kept confidential." Additionally, participants reported challenges with collaboration through statements such as: "disagreement about services needed;" "...working with providers who have biases related to mental health conditions;" and "the lack of understanding from other health care providers on how to effectively and empathically work with individuals with mental health disorders."

Lack of training. This theme was derived from participants' responses that pointed to training and understanding of the integrated care system. This was evidenced by responses such as: "the vastness of wrap around services...it's such a benefit but overwhelming to learn about the system and how it works..."; however, "the lack of specific training in integrated care" was a challenge. Additionally challenges included "...finding the time for additional training," and

“following the guidelines between insurance companies and therapy, specifically providing therapy that will work with a client’s insurance provider and how to document it appropriately.”

Open-ended question 2. What skills did you already possess that became beneficial to your work with other providers, consumers and their families? Thirty four (34) participants’ responses yielded four themes: Communication skills; counseling techniques and micro-skills; leadership and advocacy skills; and previous experiences.

Communication skills. Participants’ responses indicated that their ability to communicate and form relationships with other professionals and consumers became an essential skill that promoted functionality in an integrated care setting. A few participants simply stated “communication skills,” but other participants added skills such as relationship building, organization, and the ability to anticipate needs.

Counseling techniques and micro-skills. Participants’ responses that highlighted micro-skills and counseling techniques included the following: “basic counseling skills...knowledge of brief solution focused therapy;” “general knowledge from previous courses, as well as, counseling skills gained through my program;” and “basic understanding of wellness and helping professionals.” Others suggested person centered techniques, which were evidenced in two responses: “empathy, being kind, and non-judgmental” and “empathy...and awareness to reach out to the allied health professionals to consult and gain more information.”

Leadership and advocacy skills. This theme was developed from responses that suggested the value of skills such as flexibility, self-awareness, organizational, and collaborative skills. Some responses that emphasized these included: “I feel that flexibility has been most important in this setting;” “being adaptable has allowed me to understand each side and seeing how each side works;” “high level of organizational skills;” and “self-awareness, ability to work in a multicultural

environment.” Some participants also suggested “confidence...being able to multitask, and having organizational skills” and “willingness to speak up.” Creativity was highlighted in a response such as “...willingness to learn new systems, and taking advantage of new and different opportunities has helped me (think outside the counseling box).”

Previous work experiences. Several participants indicated that previous experiences afforded them skills that became beneficial in integrated care settings. This was evidenced by statements such as: “I had previous experience working in a large hospital and with electronic medical records...;” “I have worked on a collaborative team before in social services with law enforcement, medical doctors, advocates, abuse specialist, community members...;” and “I had training in multiple hospital settings and worked in different interdisciplinary teams.”

Open-ended question 3. Which skills or knowledge did you not have, and how did you manage to learn them? Nineteen (19) participants’ responses yielded the following themes: Supervision and consultation, learning on the job, professional development and training.

Supervision and consultation. This theme emerged from participants’ responses that indicated learning from supervisors and other professionals. In response to difficulties with medical terminology and language, participants stated: “the abbreviations and slang used in a medical setting was initially like a foreign language, but I took copious notes on rounds and consulted frequently to familiarize myself with the lingo; and “my biggest barrier was learning MD terminology, but I constantly asked for clarification.” Regarding challenges with documentation, a participant stated that “... on making concise electronic notes, I improved by practice and advice from my supervisor and professor.”

Learning on the job. Participants’ responses also showed that learning occurred based on personal motivation and curiosity. For instance, relative to documentation and medical system

challenges, participants reported the following: “most of the learning I have done on my own and applied what I did in my previous profession to the integrated care as a counselor in training;” “...I had to learn on the job the medical system incorporated into the hospital system; and “I was lacking specific knowledge on available resources and site specific policies which I have begun to learn with experience and time.”

Professional development and training. Again, the challenges with documentation, medical terminology and systemic issues persisted, but participants’ responses were coded to indicate learning through professional development and training. For instance, a participant cited, “I am lacking in understanding the systems on the doctor side of things... what certain diagnoses mean...I attend more workshops/meetings to develop this skill.” Similarly, another participant responded that “billing and coding, medical terminology...still learning through training.”

Discussion and Conclusion

The findings from this study highlight strengths and limitations relative to graduate counseling students’ perceived knowledge and skills in integrated care. Based on the overall mean score ($M = 3.95$) on the ICCS, graduate counseling students’ self-report showed competency in integrated care. Mean scores from the nine sub-categories showed that the highest mean score was on the sub-category 2 (collaboration and teamwork competencies, $M = 4.78$). With the exception of sub-category 9 (informatics competencies, $M = 3.32$) and sub-category 7 (system oriented practice competencies, $M = 3.30$) which were rated moderately competent, the rest of the sub-categories were rated at competent levels. Thus, there were no strongly competent or low competence ratings based on the overall or the sub-categories mean scores.

These findings suggest that the participants perceived their knowledge and skills about integrated care at levels that appeared to be satisfactory to function in these settings. Any

comparisons with previous studies is impossible as there are no related studies at this time. However, the positive perceptions reported by participants may be explained by a few similarities between the CACREP standards (2015) and SAMHSA-HRSA integrated care competency categories (Hoge et al., 2014). The CACREP standards (2015) do address some of the integrated care competencies including interpersonal communication, collaboration, care coordination, assessment, multicultural competencies, client-based and evidence-based practices. Consequently, the participants' reported competence ratings in seven sub-categories could be attributed to the similarity between the SAMHSA-HRSA and CACREP standards. Conversely, participants' perception could be attributed to the Likert-type scale, as there is a possibility for participants to rate themselves at the midpoint or close to the midpoint when uncertain (Creswell, 2015; DeVellis, 2012).

Nevertheless, the relatively less competence in the remaining two sub-categories (system-oriented practice and informatics competencies) seem reasonable as there are no indications that most CACREP accredited counseling programs teach students about integrated care. Although CACREP (2015) stipulates students' exposure to technology, participants may have selected relatively lower scores because of unfamiliarity with EMRs in their training programs. Moreover, a perusal of the CACREP standards did not necessarily show emphasis on the financial structure in local health systems.

Further analyses for research question 1 examined participants' levels of competence comparing selected demographic variables. Similar to the overall and sub-categories mean scores, there were no strongly competent or low competency ratings for any of the demographic variables. Students in the category of graduate degree level, exposure to training, field experience, and field placement were rated at the competent level. However, further examination showed that: (a) those

studying in doctoral programs scored relatively higher ($M = 4.54$) than those in master's programs ($M = 3.91$), (b) participants with exposure to training in integrated care scored relatively higher ($M = 4.58$) than those with no training ($M = 3.76$), (c) participants with field experience in internship scored relatively higher ($M = 4.35$) than participants in field experience practicum ($M = 4.06$) and those with no field experience ($M = 3.71$), and (d) participants in integrated care field placement scored relatively higher ($M = 4.52$) than those who indicated placement in other settings ($M = 4.07$).

These variations in the mean scores in each demographic variable could be attributed to a couple of factors. First, with experience as a factor, doctoral students may show higher competence than those at the master's degree level. Similarly, participants with specific training or field placement in integrated care settings could have leverage over their peers without such experiences. Second, differences in sample size may be a factor. For example, with a 207 difference in sample size between masters and doctoral level students, the mean score could be impacted.

Considering counseling specialties, participants' mean scores rated competent on all, except college counseling specialty ($M = 3.46$). The college counseling specialty respondents rated themselves at moderately competent. However, the growing trends of college students' mental health needs (Hunt & Eisenberg, 2010) suggest that integrated physical and mental health centers in college settings can create multiple points of entry to meet students' diverse health needs (Tucker, Sloan, Vance, & Brownson, 2008). It is unknown if college counseling specialty participants rated relatively lower because of small sample size, lack of training in integrated care, or insufficient integration at college health centers.

A further discussion of the open-ended results, show that some participants, regardless of their training and placement in integrated care settings, faced challenges. The findings in this current study are consistent with previous studies that described challenges from practicing counselors' lived experiences in integrated care (Gersh, 2008; Glueck, 2015). For instance, responses from this current study converge with Gersh's findings that described similar challenges such as medical culture related communication, time constraints, collaboration and adjustment difficulties to a new delivery system. Similarly, in both studies, participants' expressed need for training. Although students who responded to the open-ended questions had training, it is possible that didactic training may be offered concurrently with experiential training. Future studies can be conducted to ascertain participants' levels of competency when counselor trainees or licensed professional counselors have had prolonged didactic training prior to experiential training in integrated care settings.

Challenges notwithstanding, findings from this study indicated that participants believed that some prior knowledge and skills from their counselor education programs such as communication skills, counseling techniques and micro-skills, and leadership and advocacy skills may have been helpful in integrated care environments (Alvarez, Marroquin, Sandoval, & Carlson, 2014; Gersh, 2008). These already possessed skills are critical (Brems, 2001; Hoge et al., 2014) because counselor trainees can use them during professional interactions with consumers and other health professionals. Graduate counseling students learn these techniques as part of the eight common core areas in counselor preparation programs (CACREP, 2015).

In response to methods used to overcome challenges, participants indicated that purposeful training (didactic and or experiential), prolonged exposure, supervision and consultation were critical to professional functionality in integrated care settings. Training has been emphasized in

many integrated care literature (Edwards & Patterson, 2006; Johnson & Freeman, 2014). However, this study highlights supervision as another viable method of learning. Bernard and Goodyear (2014) have described supervision as the instructional strategy that demonstrates the preparation of mental health professionals. It becomes an essential tool that allows more experienced professionals to function in the role of a mentor, teacher, encourager, counselor, and or consultant. Experts have emphasized that supervision in integrated care is most significant to student-learners and interns especially when they are working in unfamiliar territories in the health care settings (Edwards & Patterson, 2006; Pratt & Lamson, 2012).

In sum, whether or not counseling students had training in integrated care seemed to affect their perception of competence in this treatment modality. Some aspects of the already existing CACREP curricula resulted in students' report of competency in integrated care. But, students' responses also show that purposeful training, specific to expressed challenges, can be essential to their perceived competence. Whether through the ICCS scores or through the supplemental open-ended questions, participants placed value on training and suggested that it ensures professional functionality in integrated care settings.

Implication for Counselor Education, Supervision, and Educators

Relevance of training in integrated care is evident in this current study for graduate counseling students and has been previously emphasized in other research studies (Gersh, 2008; Gleuck, 2015). Didactic and experiential methods have been recommended, and can help bridge the gap (McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002). Didactic experiences in integrated care can be promoted as: (a) counselor educators pursue opportunities in interprofessional education, and collaborate with other professions to develop shared courses (Johnson & Freeman, 2014); (b) counselor education programs develop integrated care as an

elective course; (c) programs employ intentionality regarding field experiences; (d) counseling programs integrate learning opportunities in existing courses such that students can shadow practicing counselors in integrated care settings to increase interaction with other health professionals; and (e) field experiences in practicum and internship supervision classes can be intentionally designed to include case conceptualization models that promote discussions about integrated care concepts.

Professional counseling is moving beyond the realms of traditional counseling settings to a more integrative setting as graduates begin to build knowledge and skills required for holistic care. It is encouraging that six out of the 15 counselor education programs recruited for this study have existing curricula that is fostering integrated care learning. Taken together, there is evidence to support the call for exposure to integrated care concepts in counselor preparation programs, as well as creating opportunities for professional development for practicing professional counselors and supervisors.

Limitation and Future Research

Further research should consider evaluating actual competencies versus perceived competencies to help establish the relationship between students' self-report and faculty-based or site supervisor assessment. Creswell (2015) asserts that surveys can be used to collect data quickly and extensively, but sometimes researchers run the risk of responses being subjective. While the study was more exploratory in design, it might be pertinent to investigate the topic of competency in detail. Regarding the qualitative section of the study, future studies could extensively explore students' experiences in integrated care by conducting pre-post interviews of counseling students in practicum and internship settings. This would provide rich understanding into students' expectations, perceptions, and assumptions related to pre-and post-integrated care experiences.

Furthermore, focus groups pertaining to students who have had experiences in integrated care could provide rich data that can be triangulated for in-depth understanding of students' experiences.

Given the dearth in integrated care instruments, larger sample size could be used to establish the ICCS on perceived or actual competencies in integrated care. Although this study used reasonable sample size and randomization as part of the sampling framework, it is difficult to make definitive inferences. Several validation processes such as pilot testing, cognitive interviews, and expert reviews were used to ensure that the measure was appropriate for data collection. Nevertheless, future studies could further examine participants' demographics to ascertain correlations and variations in their perceived competencies. Additionally, limited literature on integrated care perceived or actual competencies cut across most behavioral health professions. Hence, it is recommended that further studies be conducted to include professional counseling and other behavioral health training programs. This could provide detailed information about participants' perception or actual competencies and variations that exist regarding efforts to train the behavioral workforce for integrated care services.

In conclusion, this study is relevant because it provides an understanding into students' perceived competencies as it relates to SAMHSA-HRSA integrated care competency categories. Counseling as a profession can begin discussions focused on making graduates well-grounded in integrative services, while creating more employment avenues for its graduates. AMHCA and the American Counseling Association (ACA) have taken on the challenge in encouraging this effort. Therefore, researchers, counselor educators, and supervisors should embrace the challenge to lead the way in bridging this gap between competencies and practices of behavioral health counselors working in integrated care environments.

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