

A PHENOMENOLOGICAL INQUIRY TO UNDERSTAND ENVIRONMENTAL  
WORKPLACE FACTORS, ACADEMIC TRAINING READINESS, AND  
SUPERVISORY NEEDS OF INTERPROFESSIONAL COLLABORATIVE  
COUNSELORS

by

Michelle Kipick Cawn

A dissertation submitted to the faculty of  
The University of North Carolina at Charlotte  
in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy in  
Counseling

Charlotte

2014

Approved by:

---

Dr. Pamela S. Lassiter

---

Dr. Lisa Merriweather

---

Dr. John Culbreth

---

Dr. Susan Furr

---

Dr. Elizabeth Stearns

© 2014  
Michelle Kipick Cawn  
ALL RIGHTS RESERVED

## ABSTRACT

MICHELLE KIPICK CAWN. A phenomenological inquiry to understand environmental workplace factors, academic training readiness, and supervisory needs of interprofessional collaborative counselors. (Under the direction of DR. PAMELA S. LASSITER)

The multi-professional health care setting calls for a stronger evidence-based practice for providing collaborative framework/theory across disciplines. The purpose of this study was to develop an understanding of the perspectives of counselors who practice in Interprofessional Collaborative (IC) settings related to training and support needs. Interviews were conducted with 10 licensed or associate licensed counselors with experience working on integrative behavioral and mental healthcare teams. A qualitative design was used to explore counselors' lived experiences and the factors that influence their practice environment and supervisory needs.

A phenomenological data analysis procedure using an Ad Hoc technique for interview analysis was used to analyze the data. Participant perspectives were framed by analyzing the individual emic perspectives and then the overall composite or etic perspective. The analysis indicated that there were common themes across participants working within an IC environment. Themes of mutual responsibility, disconnect, and isolation served as the common thread for the participants working in this practice culture.

The findings suggest that counselors working in integrated collaborative care environments could benefit from support from both counseling education programs as well as on-site supervisors. Providing additional training that addresses collaborative care with allied disciplines and coursework in understanding medical terminology, in an

effort to improve readiness for students in counselor education programs, is necessary to both prepare and support new counselors. Additionally, research is needed that continues to expand the knowledge base of support for counselors in IC settings in order to help prepare counselor educators and supervisors as to what will be needed to meet the needs of those practicing at internship, associate, and post-licensure levels.

## DEDICATION

This research is dedicated to my husband, Brent Cawn, and three children, Sophia, Olivia, and Gabe who stuck with me, providing love, patience, and sacrifice to help me realize my goal. My gratitude is immeasurable and appreciation more than I have words to express.

## ACKNOWLEDGEMENTS

There are many individuals who have encouraged and supported my efforts towards the completion of this dissertation. First, I would like to thank my committee members for their time, feedback, and support offered during this process. Dr. Elizabeth Sterns, I appreciated your commitment to support me throughout this process and to provide feedback that helped to improve the overall quality of this study. Dr. John Culbreth, your passion and advocacy for the counseling field and support for the supervisory needs of counselors inspired me to focus attention in this area of research. Dr. Susan Furr, I appreciated your views from a multi-disciplinary background as you provided wisdom, guidance, and supervisory knowledge in the field along with ongoing encouragement. Dr. Lisa Merriweather, your expertise in qualitative research along with your patience and devotion of time to mentor and support my needs was a unique gift, one that I wish every student would have the opportunity to experience. Dr. Pam Lassiter, as my chairperson your knowledge of the field and ability to keep me focused along the way was invaluable. I appreciated your systemic views and creativity that brought energy to the process and supportive and caring nature helped to keep me on track.

This is not a simple process and I appreciate those that provided added support along the way, especially Dr. Lyndon Abrams, a constant calming presence and Dr. Hank Harris, providing direction and encouragement. Dr. Ng, you were my greatest supporter when I began putting my initial ideas together for this study and your contributions guided the foundation for this research. Dr. Travis Bobb, your supportive guidance and

views on improving counselor experiences in supervision, especially those practicing in interdisciplinary environments, helped me to maintain the focus on the purpose for this study. To my independent reviewer, your help during this process provided a constant perspective and objectivity to the qualitative design and your patience and dedication to the research content. I would also like to thank the research participants, their stories and experiences brought an added appreciation for their perseverance for improved quality client care, even when faced with challenges in their workplace environments.

The inspiration for this multi-disciplinary study came from some of my first supervisors, whose teachings encouraged me to think collaboratively and always be open to learning from others. Dr. Jon Winek, your mentorship over the years and focus on positive client care encouraged my systemic foundation for this research. Dr. Wayne Denton, you set the bar high for internship experiences, and wish that every student would be able to learn from your views on collaborative and multi-disciplinary team supervision.

I would also like to thank those closest to me, my family and friends for being my greatest cheerleaders. To Catherine Zanga, your friendship and belief in my abilities in life and career was a constant source of positive influence for me. To my parents, you instilled the importance of persistence, dedication, equality, and humility, traits that influenced my direction in life and choice to focus on the needs of those who tend to be neglected in healthcare, the helpers themselves.

## TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION	1
Statement of the Problem	5
Conceptual Framework	6
Purpose Statement	7
Research Questions	7
Significance of Study	8
Research Design	10
Theoretical Framework	10
Sampling	11
Assumptions	11
Limitations	12
Delimitations	12
Definition of Terms	12
Organization	14
CHAPTER 2: REVIEW OF THE LITERATURE	16
Biopsychosocial Model	16
Levels of Care	17
Emergence of Interprofessional Care	18
Trends in Interprofessional Collaboration	19
Training and Support for IC	20
IC Competencies	23
IC Supervision	23



Generic Supervision	25
Counselor Education and Supervision in IC	26
Academic Training Readiness	27
Counselor Competencies	27
Integrated Settings	30
Counselor Supervision in IC Settings	30
Identity Development Model	31
Supervision Framework	33
Ethical Considerations	33
Counselor Perspective of IC	34
Emic Perspective	34
Counselor Lived Experiences	35
Etic Perspective	36
Summary and Conclusions	38
<b>CHAPTER 3: METHODOLOGY</b>	<b>40</b>
Author's Note	40
Introduction	42
Research Questions	42
Research Methodology	42
Justification for the use of Phenomenological Analysis	43
Systemic Theoretical Framework	43
Research Procedures	45
Sampling and Location	45

Aggregate Descriptions	46
Design	47
Interview Purpose and Researcher's Role	47
Interview Guide	48
Informed Consent	48
Data Collection	49
Reflecting	50
Data Analysis	51
Verification of Interpretation	53
Summary	54
<b>CHAPTER 4: THE LIVED EXPERIENCES OF COUNSELORS</b>	<b>55</b>
Introduction	55
Emic Perspectives	56
Participant One	56
Participant Two	60
Participant Three	64
Participant Four	68
Participant Five	71
Participant Six	74
Participant Seven	77
Participant Eight	80
Participant Nine	84
Participant Ten	86

Composite: Etic Perspectives	90
Mutual Responsibility	92
Disconnect	96
Isolation	100
Summary	103
CHAPTER 5: DISCUSSION	104
Introduction	104
Workplace Factors	105
Academic Readiness	108
Supervisory Needs	109
Limitations	111
Participants	111
Telephone Interview	111
Researcher Subjectivity	112
Implications	112
For Practice	113
For Counselor Education and Supervision	114
For Future Research	115
Summary	116
REFERENCES	117
APPENDIX A: DEMOGRAPHIC FORM/SCREENING QUESTIONS	123
APPENDIX B: INFORMED CONSENT FORM	124
APPENDIX C: INTERVIEW GUIDE	126

APPENDIX D: RECRUITMENT LETTER

## CHAPTER 1: INTRODUCTION

### Overview

As a psychology major, I was highly influenced by the medical model and its emphasis on the distinction between the function of the mind and body. It always seemed a mystery that while the brain was part of the body, working in unison, the 'mind' was simultaneously working as a separate functioning system, a sort of black sheep to the body. If someone is anxious, why then does his or her heart race? If there is dualism to human functioning, why would symptoms for a psychologically-based issue impact the physical functioning? The paradigm of mind versus body never made sense to me, but still I grew up learning within its context.

This paradigm has historical roots in Cartesian dualism that can be traced back to the seventeenth century with René Descartes and his conception of the mind and body as distinct systems, (Serlin & DiCowden, 2007). The historical/political roots of the medical establishment and the advancement of the scientific method provided the context in which these ideas were developed. Centuries later what may have worked within Descartes' culture may no longer have relevance within the healthcare climate of the twenty-first century.

As Freud helped to broaden our understanding of mental health functioning with his psychoanalytic approach, behavioral health disciplines continue offering a range of theoretical frameworks to explain mental illness and treatment modalities. As a society we have hospitals and mental health hospitals, healthcare and mental healthcare, medical care and behavioral healthcare. This fragmented view of human health and functioning

has contributed to a failure to understand the dynamic nature of people and to offer effective interventions. Throughout the health and wellness literature there is a resounding theme: the dualistic paradigm is being replaced with a new integrated care philosophy.

These shifts in the healthcare system come at a time where mental illness is a leading cause of disability in our country, according to the President's New Freedom Commission on Mental Health (2003), with depression anticipated to become the number one cause of disability by the year 2020. While the healthcare field witnesses a rise in mental health related illness, advocacy at the national and international levels, by the World Health Organization (WHO) and the President's New Freedom Commission on Mental Health (2003), has created a call to action to find ways to improve the mental health system. Additionally, strong recommendations have been suggested to address the crisis of decreases in funding, poor quality of services available, and a shortage of psychiatrists needed to prescribe psychotropic medications. Leaders in the mental health field have suggested engaging multiple disciplines to collaborate for systemic improvements on client health as a possible solution that would lead to a reduction of overall spending, improved quality in the care provided, and more accessible mental health services (Appelbaum & Gandell, 2003; Roberts, Robinson, Stewart, & Smith, 2009).

Collaboration, or integrated care delivery, would address what Applebaum and Gandell (2003) labeled a "nonsystem" of care, one that is fragmented based on individual allied health views. Terms such as silo or fragmented care can be found throughout the integrated health literature and generally refer to services that are segmented by

discipline, such as hospitals that are divided by mental health or medical service delivery. With decreased funding for mental health services, it stands to reason that individuals and professional groups focus on keeping their own disciplines financially viable in a changing economic time. If these same disciplines are provided an alternative message of change, one that identifies the disciplinary strengths that are needed for a better form of client care, the benefits of collaborative work may become less about the helpers' survival techniques and more about those receiving the care. Additionally, an integrated system would lead to a more holistic perspective that merges mental and medical care.

In 2005, integrated health delivery was identified to be a priority by the President's Commission on Mental Health for the purpose of more collaborative practices and as a more affordable solution to the mental health crisis (Enochs, Young, & Choate, 2006). Trends towards this integrated delivery model have been further substantiated with shifts in current economic paradigms, such as the mental health parity legislature that ends separate deductibles for mental health related services and provides incentives for primary care providers to offer a mental health component as part of the routine treatment process (Terhune, 2012). According to Roberts, et al. (2009), people most often seek help for mental health issues in non-mental health facilities, often from their primary care physician. As funding continues to decrease for stand-alone mental health services, the industry will continue to witness a shift from psychiatry to primary mental health care.

As the healthcare climate changes, individual disciplines have responded with collaborative efforts that address training needs in order to function in multi-disciplinary environments. Interprofessional Collaboration (IC) is a term used to describe multiple

disciplines who work together from both medical and mental health care backgrounds. IC as a framework for care delivery has roots that can be traced back to the 1970s with the emergence of the biopsychosocial model (BPS). The BPS model views human functioning from a more holistic paradigm that connects the mind, body, and culture to overall health (Engel, 1977). Some disciplines have joined together to form integrative efforts to increase knowledge of best practices and training needs for IC settings. Integrated movements such as the Collaborative Family Healthcare Association, the Integrated Behavioral Health Project, or the Interprofessional Competency group are just a few of the attempts at helping bridge the divide across the multi-disciplinary healthcare field.

Evidence of the changing paradigm towards holistic care delivery within the past few decades can be seen in the collaborative efforts to increase training competencies in IC. The Interprofessional Education Collaborative, comprised of six allied medical professions, published a report in May 2011 that outlines a framework of best practice competencies specifically related to the interprofessional collaborative healthcare setting. The 2011 report illustrates an emerging concept of Interprofessionalism (D'Amour & Oandasan, 2005) as a field comprised of more than one allied health professionals working together with a common goal and purpose, with respect for individual contributions to an interprofessional team. For those preparing for careers in this new integrated health environment, competencies, in addition to those in their individual disciplines, are a must. Areas of academic training requirements and clinical practice models are critical to understanding the frameworks that most support needs for the counselors who enter these environments. In order to deepen the field's understanding of



the factors that influence a counselors' experience as a collaborative professional, it is important to recognize these shifts in mental health delivery as a contextual backdrop for further exploration of trends in academic and supervisory needs as related to interprofessional care.

### Statement of the Problem

The counseling discipline is a growing profession that contributes to the mental health field in a wide range of practice settings. Even though counselors have suggested advocating for interprofessional collaboration between the mental health disciplines (Lopez-Baez & Paylo, 2009; Myers, Sweeny, & White, 2002), accreditation standards for counselor educators have not clearly defined interprofessional competencies (the Council of Accreditation of Counselor Related Education Programs--CACREP, 2009, 2016-draft), and research from the field is grossly underrepresented. Consequently, some counseling professionals discuss integration as a new and emerging trend needing further attention rather than as a system that has been evolving for more than 40 years (Aitken & Curtis, 2004).

In contrast to the counseling field, other mental and medical health disciplines have been at the forefront of research in IC care, including literature in support of supervisory models specific to the combined mental and medical workplace environment (Davies, Tennant, Ferguson, & Jones, 2004; Edwards & Patterson, 2006; Hernandez, 2008; Thomasgard, Warfield, & Williams, 2004). The medical community has created training competencies specific to interprofessional collaborative care (IECEP, 2011). This document provides a suggested framework for academic readiness and the structure needed to put IC competencies into practice. For over two decades, social work,

psychology, primary care, nursing, and medical family therapy have developed understandings of what these IC competencies mean for their respective disciplines. These pivotal understandings that could help shape the academic learning and ongoing support within these collaborative environments are lacking in the counseling field.

### Conceptual Framework

The scope and purpose of this study are defined by two frameworks: academic readiness and supervisory support. Academic readiness in the field of counselor education is most influenced by the required competencies set forth by CACREP (2009). These standards provide an outline for best practice skill instruction for academic programs. Supervisory support provides for the management of clinical practice needs throughout the counselor's professional development. The Association for Counselor Education and Supervision (ACES) released a Task Force Report in 2011 for best practices in clinical supervision. While the two frameworks, academic readiness and supervisory support, will be discussed in more detail in the literature review, a brief overview will be provided now.

The CACREP standards provide an outline for best practice skill instruction for counselor educators. Although these standards influence the curriculum development within these academic programs, they currently lack competencies specific to IC (CACREP, 2009). Some counseling professionals such as Shallcross (2013) have offered support for specific skills needed to function in IC settings, such as knowledge of medications, brief therapy practices, wellness-based approaches, and family systems work, this knowledge is not informed by research findings, but rather through shared experiences of working within IC settings. In a recent issue of *Counseling Today*

(October 2013), Jacobson raises a valid concern that, if the counseling field does not teach what needs to be taught for interprofessional care, counselors will learn from other professions how to work within these environments. Are we as a part of this allied health community going to be satisfied with taking a position of silence in this important area of development of mental health delivery?

Just as CACREP dictates best practice for academic programing in counselor education, the goal of the 2011 ACES Task Force Report was to “formulate a relevant and useful set of best practice guidelines for clinical supervisors, regardless of work setting” (p. 1). The report was intended to support current supervisors as well as academic training programs for the education of supervisors. Included within the section of the ACES report is an emphasis on the need for different approaches based on the setting for supervision including supervision-training instruction that would include supervision models relevant to the practice setting and supervisory needs. The ACES task force document emphasizes that supervision training should view “the supervisory relationship as the primary vehicle for learning in supervision” (p. 16). These supervisory competency areas are relevant to supporting counselors within the IC settings where supervisors will need to integrate their own self-awareness with cultural and systemic differences that may impact the development of the supervisee.

#### Purpose Statement

The purpose of this research study is to develop an understanding of the perspectives of counselors who practice in interprofessional collaborative care settings, related to academic training readiness and supervisory needs.

### Research Questions

The research study was a phenomenological analysis of professional counselors working within IC settings. Three questions helped to guide the qualitative inquiry: What workplace factors influence counselors who practice in interprofessional settings? How does academic training readiness impact counselors working in IC settings? What are the supervisory needs of counselors working within IC environments? The study sought rich descriptions from counselors who functioned as part of an IC treatment team that might help inform practice and supervisory needs.

### Significance of Study

The increased knowledge that these rich descriptions will provide can inform future ideas and research of how to best support counselors in these environments. Although the counseling field lags behind the movement toward integration of both theory and research, the hope is that this study will help to contribute to a body of knowledge about IC care that could help inform best practice and advance the conversation about theoretical foundation for the counselors in these settings.

If interprofessionality is in fact an emerging field, counselor education and supervision will need to undergo a conceptual shift to understand the changing environment where counselors influence client care. Then, interprofessionality research could focus on better understanding the interdependent relationship between interprofessional education (accreditation structures) and collaborative practice (professional systems) as a means to enhance learner and patient care outcomes (D'Amour & Oandasan, 2005).

In 2011, the *Journal of Counseling & Development* published an article that highlights the trends for the field and the vision for the future of the profession (Kaplan & Gladding, 2011). The article compiled ideas from 30 counseling related organizations and associations over a three-year time frame with seven main principles needed to advance the profession. The importance of expanding and promoting research within the field was one guiding principle from the document, which pointed out that “many best practices are dictated to counselors by other mental health professions” (p. 371). This point supports Jacobson’s 2013 comments that counselors will have to learn to navigate a changing system, and, if they do not learn how to do this from within their own discipline, the education will come from on the job experience within other practice areas.

The *Journal of Counseling & Development* published an additional article within the same 2011 summer volume that presented a 10-year review of the counseling research (Ray et al.). These authors reviewed over 4,000 articles in division-affiliated journals from the American Counseling Association. The authors found that 90% of the studies presented findings from non-clinical populations and were limited in focus in the areas of counselor education (3%) and supervision (2%). With a dearth of counselor research dedicated to clinical issues, coupled with the contextual shifts in healthcare delivery, the question becomes "How are counseling professionals able to move forward with guiding principles that truly capture their needs so that they can best serve their clients?" Since this new healthcare movement will demand collaboration with and knowledge of other disciplines, it is imperative for the counseling field to develop competencies related to both academic training and supervisory needs.

Currently, the field of counselor education lacks a presence in integrated health care research, yet counselors continue to be part of these environments as interns and professionals. It is incumbent on us as a field to listen to the voices of these counselors and to understand how they make sense of their role in this setting. By reviewing the rich descriptions given by counselors of how they make meaning of their role in multi-professional groups, we will be able to expand our knowledge of what is needed to support counselors within a new cultural context.

### Research Design

A phenomenological inquiry provided the framework for this research study, which is an appropriate methodology for a study that seeks to understand better the interpretations of interprofessional care from the counselors' perspective, as phenomenological approaches study the meaning and interpretations individuals make from their experiences (Loftus & Higgs, 2010). This understanding is critical to facilitating positive practice outcomes in collaborative settings. Consistent with a qualitative phenomenological design, in-depth interviews followed a semi-structured interview format used to collect first-person counselor perspectives of their interprofessional collaborative experience. Ten participants were recruited from similar IC settings.

### Theoretical Framework

General System's Theory will serve as the framework for this study as the focus for individual experience can incorporate an emic view of an individual within his or her environment or be described from a larger context of influence. The ecological paradigm (Bronfenbrenner, 1979) fits well within the theoretical foundation of systemic

functioning. The interpretation of a person's workplace can be understood from a multi-layer view of knowledge and how we make meaning and define our environment. This multi-layered view helps us to consider the impact on developing counselors, by framing interpretations of their world according to their systems of influence.

### Sampling

Purposive sampling was used to recruit participants who graduated from a CACREP counselor education program and worked in an IC setting with a treatment team approach that includes at least four disciplines, with at least one from the medical profession. Interviews were audiotaped and then transcribed. A semi-structured interview guide helped to provide a similar outline for all interviews while being inclusive of the scope of the study (Appendix C). The personal accounts provided for rich descriptions of the counselor interpretations of their practice environment and how they connect with the larger context of interprofessional collaborative care.

Consistent with qualitative designs, auditing occurred throughout. Participant reflections of the transcribed interviews helped to ensure an additional layer of integrity to the study. An independent coder familiar with qualitative analysis and the researcher reviewed the data entered on a spreadsheet representing multiple sources of information. Kvale and Brinkman's (2009) Ad Hoc techniques for interview analysis served to guide the organization of the data. A matrix was created to help to illustrate themes and categories identified from the participant data.

### Assumptions

Several assumptions helped to provide a foundation for this study. First, it was assumed that the participants in this study would answer the questions in an accurate and

honest way during the interview. A second assumption was that certain themes would emerge from the recounted experiences of counselors practicing in interprofessional collaborative settings. A final assumption was that the counselors would have their own unique ideas about what changes need to be made to counselor training and supervisory activities based on their unique experiences and professional development.

#### Limitations

Although participants were selected with similar professional backgrounds and practice settings, they differed in their professional experience and specific cultural context. The data obtained through these subjective accounts was self-reported and therefore difficult to generalize. The size of the sample limited the diversity and generalizability.

#### Delimitations

No additional allied mental health professionals were included in this study and it was delimited to professionally licensed or licensed associate level counselors with similar graduate experience.

#### Definition of Terms

A definition of terms is presented that combines language from various professional disciplines. In some cases where multiple definitions could be used, the researcher presented the meaning most frequently used across the literature.

The Biopsychosocial Model (BPS) is defined as a healthcare approach used in health assessment and treatment that incorporates biological, psychological, and social components for a more holistic framework of health functioning (Engel, 1977).

Challenging the traditional dualistic paradigms of mind/body disconnect under which the



present health care system operates, the BPS model posits an integrated care philosophy with an added emphasis on multi-professionals working in unison to improve client outcomes.

For the purposes of this study, the term Collaboration will be used to describe the process of sharing information with other healthcare professionals from distinct disciplinary backgrounds with a common goal to improve client outcomes.

Integration will be operationally defined as a culture of professionals operating with inter-dependence with an ecological focus that includes influences by a larger socio and political system of care. Interprofessional Collaboration (IC) is the general term used throughout this study that refers to a team-based approach to healthcare delivery that utilizes a multi-disciplined group of health and mental health professionals who share responsibility for a client or family (adapted from the Interprofessional Education Collaborative Expert Panel Report of an Expert Panel--IECEP, 2011). Members of the IC team contribute insight from discipline specific skill sets with the common goal to provide optimal service to those they serve.

The Interprofessional Collaborative Team could include counselors, marriage and family therapists, social workers, primary health physicians, psychologists, psychiatrists, qualified professionals, psychiatric or primary care nurse practitioners, or physician assistants.

The term professional counselor refers to an individual who has completed his or her academic training in counselor education but may have varying degrees of professional experience. A Licensed Professional Counselor Associate (LPCA) can be operationally defined as a mental health professional who has recently graduated from a

counseling related program and, is considered under provisional licensure, competent to practice with ongoing supervision from an approved qualified counseling supervisor. A Licensed Professional Counselor (LPC) is a mental health professional who has met all educational, clinical, and supervision hours to meet the requirements for state licensure in the field of counseling.

For the purposes of this study, a Treatment Team Site will refer to a location in which multiple healthcare providers function within the framework of Interprofessional Collaboration (IC), with the goal to improve the integration of behavioral and biomedical healthcare delivery (adapted from the IECEP report, 2011).

### Organization

Chapter One presents an overview of a changing paradigm in healthcare delivery from a dualistic view of human functioning to a holistic-care philosophy. Challenges to traditional mental healthcare have questioned the current failing system and permitted the emergence of interprofessional collaborative care as a solution to improve the state of mental health delivery. As IC populates the mental health landscape, there is a need to understand better how to support and train counselors by learning from their own lived experiences within these practice environments.

Chapter Two includes a comprehensive review of literature, which further explores the research and the lack of clarity as to what defines interprofessional competencies for the counseling field. Areas of academic readiness and supervisory needs provide a framework for this study and will be presented in detail in Chapter Two. Academic readiness will be addressed within the context of the accreditation standards set by the counselor education field (CACREP) and will highlight how core knowledge

areas relate to competencies relevant to IC settings. Supervisory needs in relation to IC care and support will also be addressed with a review of supervisory best practice standards as well as an overview of supervisory models of practice. The final section will validate the need to understand counselor-related research within IC settings based on the lack of counselor research within this area as compared with other allied healthcare providers.

Chapter Three will present the research methodology for this study. Systemic theory using an ecological view of IC will provide for a theoretical foundation. A phenomenological approach will be explained and the research process detailing participant selection, the interview process, and the procedural steps used to analyze the data. Steps to enhance the reliability, validity, and verification process will also be outlined.

Chapters Four and Five will include the research findings and provide a discussion of emergent themes relevant to a broader body of literature on IC delivery and the impact for counselors, educators, and supervisors. Recommendations for future research will also be discussed.

## CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this chapter is to provide an overview of the current literature related to the practice of interprofessional collaborative care and its relevance to the mental health counseling professional. Four factors will be highlighted related to the interest areas of interprofessional collaboration and the professional counselor. The first factor to be reviewed is the biopsychosocial model (Engel, 1977) as the leading theoretical lens utilized in interprofessional settings. The second factor that will be examined is the history of integrated care and the interprofessional collaborative setting. The third factor to be explored will be research pertaining to the education and supervision of the professional counselor within this integrated model of care. The fourth section will outline the dearth of research currently available to counselor educators that addresses the interprofessional collaborative setting.

### Biopsychosocial Model

The integrated health community is heavily influenced by George Engel's (1977) biopsychosocial (BPS) medical model, populating much of the research across disciplinary fields as the foundation used in combined mental and medical health care settings (Frankel & Quill, 2005). Developed at the Rochester School of Medicine where George Engel trained residents on patient care, the roots of the BPS model incorporate the medical model as it merges biomedicine with psychosocial indicators for a more holistic view of human functioning (Engel, 1977; Mills & Sprenkle, 1995). Engel took a systemic approach to health care delivery that would encourage medical residents to understand not just the disease and illness but also the extended systems of influence

around that client (Frankel & Quill, 2005). The BPS approach is an inclusive view of illness and disease in that one influences the other mutually and cannot be separated. Physicians are encouraged to assess aspects of physical, psychological, and social functioning with each visit, and residents are encouraged to incorporate the BPS model during their medical training (Engel, 1977; 1980).

Since 1977, several adaptations to the original BPS have been released. In 1989, Joseph Herman expressed the need for a newer transitional model of care, claiming that the time needed to interact with every patient using the BPS model meant it would eventually need to be replaced by a more expedient model of care delivery (Herman). Frankel and Quill (2005) offered different findings in contrast to the statements made by Herman, showing that, while on average, use of the BPS model might add one minute to the encounter, client satisfaction increased when patients felt that their physician was listening and cared about them. Adaptations to the original BPS model continue, and terms such as "patient-centered care" and "the medical home" highlight the synergy between the patient and his or her care providers.

#### Levels of care

Following Engel's basic format for the use of the BPS model, Doherty, McDaniels, and Baird (1996) further outlined levels of systemic collaborative care to suggest a framework for the primary care setting. Doherty et al. highlighted the fact that the labels of integrative versus collaborative care were often used interchangeably and inconsistently. Blount (2003) more narrowly defined these frameworks as: coordinated (separate locations non-shared treatment plan), co-located (shared location with separate treatment plans and shared access to medical records), and integrated (often shared treatment plan within the same location). These contributions have helped bring to light

models of different levels of professional communication yet they lack a unified cultural theoretical lens.

Research studies that used the BPS model, such as Roberts et al. (2009), suggest that medical environments, such as primary care settings, are the most common resource for mental health needs, a shift from the traditional mental health stand-alone facilities. These changes provide a backdrop to the advancement of shared care that is co-located and further help to set the stage for interprofessional collaboration, an integrated care framework.

#### Emergence of Interprofessional Care

Although there are several terms that can be used to describe the integration of services that include medical and mental health care delivery, for the purposes of consistency the term Interprofessional Collaboration will be utilized. With the backdrop of changes in the new multidisciplinary setting for mental health care delivery, all allied health providers have been encouraged to adopt an integrative model of care that will incorporate aspects of the BPS model to help reduce costs and patient encounters (Frankel & Quill, 2005). The term interprofessional collaboration more accurately depicts the current trends towards an integrated care system that function together as a treatment team. The benefits of using a more holistic model of collaboration with integrated health delivery are well described in the literature and highlight needed improvements in areas of service quality, reduced spending, and accessibility.

#### Trends in Interprofessional Collaboration

While researchers from the medical disciplines such as Margalit, Glick, Benbassat, and Cohen (2004) and Roberts et al., (2009) reported a reduction of healthcare costs and an increase in patient satisfaction when an interprofessional collaborative

framework was used, the literature also points to potential barriers in communication between disciplines. Thomasgard et al. (2004) reported communication barriers to collaboration and cite the need for a collective structure to help guide these multi-professionals. Harkness, Smith, Waxman, and Hix (2003) echoed the need for continued interdisciplinary training and suggest that “if healthcare providers continue to lobby only for their own best interest then the separate care approaches are just perpetuated. Somehow joining forces and crafting legislation seems a much more powerful alternative” (p. 99). This view supports an overriding message that as a collective group of allied health professionals we may build a more effective patient care system than we could as discipline specific individuals working in isolation.

Because medical professionals immersed in collaborative care settings have many demands for their time and attention, the literature suggests that mental health providers will be expected to enter the workplace environment well versed in collaborative language and skills relevant to a broad range of integrative demands. A comprehensive review of the current literature on IC that includes disciplines from outside of the mental health counseling field highlight the need for improved academic training readiness and more appropriate models for supervision in a multidisciplinary setting. The following section will outline contributions from non-counseling allied health disciplines in the areas of IC research and practice competency areas.

#### Training and support for IC

Support for the IC model has been most prevalent within the medical community. In 1999, the Accreditation Council for Graduate Medical Education (ACGME) included communication and interpersonal skills and systems-based thinking as two of the six main competency areas for medical practice (Frankel & Quill, 2005). In 2000, the

Institute of Medicine (IOM) claimed large numbers of preventable harm and deaths occurred when there was a lack of communication and relationship between physicians and patients (Frankel & Quill; IOM). Additionally, patient satisfaction surveys, analyzed by Frankel and Quill, provide a compelling reason to believe that the integrated BPS model of care is effective and “has a significant impact on patient satisfaction” (p. 418).

A 2004 study by Margalit et al. reported results that included fewer medications prescribed and reduced lab exams conducted when psychosocial assessments were included during healthcare visits. The review anticipated reductions in health care costs, a reduction in additional tests and medication, and an increase in overall patient satisfaction. Positive service and economic results noted by this study further reinforce the benefits of the use of the IC in medical practice settings.

Perhaps one of the largest research studies on mental health delivery within a medical setting comes from Miller, Teevan, Phillips, Petterson, and Bazemore (2011). After analysis of over 87,000 adult visits to primary care physicians over a four-year period, the results from this longitudinal study found that visits that included a mental health component increased the length of the patient encounter by only three to four minutes. Miller et al. stressed the importance of such findings since the delivery of mental health care takes place in primary care more often than in any other setting, and increasing time per visit is a concern for a new business model that pushes for increased volume. These findings identified the frequency of mental health issues being identified or addressed during in primary care office visits and provide justification for the need for IC in order to maximize the efficiency of medical staff (Miller et al.).

Ruddy, Borresen, and Gunn (2008) present a collaborative view of integrated care from the field of psychology. Rather than fully incorporating Engel’s medical model,



they stress creating relationships that are more reciprocal. From this perspective, the psychologist would co-locate with medical professionals (physicians, nurses, physician assistants) and communicate as needed on patient care without fully integrating as part of a collective team (Ruddy et al.). This distinction between co-location and integration is the co-located perspective mirrors a more individualistic approach to providing care where the provider focuses on their individual academic skill set instead of sharing these skills as part of a client centered team. Ruddy et al. (2008) suggest that two decades of literature continue to support collaborative psychotherapy and its reciprocal relationship with the medical profession.

In contrast to a co-located approach, Roberts et al. (2009) focused on care from an integrated perspective, pulling on disciplinary strengths to build an effective care client centered treatment team. Robert et al. reported positive findings, including a reduction in fragmented patient care, when an interprofessional framework was used during a mental health rotation with multidisciplinary staff. This idea reemphasizes the need for better understanding of the interprofessional relationships that utilize individual discipline strengths and integrated care practice models.

One example of integrated care training models comes from the field of Medical Family Therapy (MFT) where programs have increased the knowledge of and training in the areas of biomedicine and psychosocial needs. MFT students retain a systemic theoretical foundation while operating within the confines of medical terminology or culture (Mills & Sprenkle, 1995). As with the MFT, a counselor could retain his or her developmental theoretical foundation while gaining knowledge of alternate disciplinary models of care.

Stein (1988) suggests that “the issue is not or at least should not be, bridging disciplines A and B, but teaching patient (client) care. That deserves to be the unshakable foundation of all that we do” (p. 118). It seems that Stein was at the forefront of this new paradigm of IC care. In Stein’s ethnographic research study, he grounded his assumptions in the contextual frame of biomedicine and focused on systemic factors of influence in his training model including multi-disciplinary collaborations. Stein retained his theoretical roots in the medical model and also emphasized the importance of remembering that for any healthcare provider patient or client care should be the priority.

According to Hays et al. (2002), there is a disparity between training and practice. Better understanding of the goals of the new mental health climate would help those who are training the clinicians and their supervisors make the necessary transitions as well. Notably absent, however, is research that expands our knowledge of what is needed to support integrative mental health that values an individual’s professional discipline. To understand the dynamics of the collaborative relationships, additional research from the perspective of those in clinical practice would allow the opportunity to understand better their lived daily experiences. By understanding the perspective of a few within the system of care, we better understand the needs of a team of professionals that influence mental health treatment.

### IC Competencies

In 2011, the Interprofessional Education Collaborative Expert Panel (IECEP) produced a document that outlined core competencies for the practice of interprofessional collaboration. This document highlights the importance of interdependence between interprofessional education (focusing on multi-disciplinary learners about various systems of care) and collaborative practice (which enhances client care). Competency

areas are divided into four domains of IC practice: 1) values/ethics for interprofessional practice, 2) roles and responsibilities, 3) interprofessional communication, and 4) teams and teamwork (IECEP). This expert panel consisted of allied health professionals from the medical health field, and the document represents the efforts of the IC leadership to implement changes in IC care that will impact all professionals across many disciplines.

### IC Supervision

Reid et al. (1999) looked at the impact of burnout and stress in a multi-professional mental health facility. Using a qualitative design, they determined that a more formal structure of supervision would improve employee functioning and maximize effectiveness in an interprofessional setting. The authors suggested that supervision with the inclusion of professional development and skill training, such as Stoltenberg, McNeill, and Delworth's (1998) Identity Development Model (IDM), would allow for a flexible experience and would create a space in which the mental health clinician is able to develop and grow based upon their field and expertise.

The Cultural Complexity Model (CCM) of supervision (Hernandez, 2008) includes themes such as structure, flexibility, balancing, and broadening and narrowing of focus. This expansive approach to supervision allows for differences and unique contributions while viewing the familial and cultural lens. Hernandez discussed the use of genograms and measurable competencies to help the supervisor understand the supervisee's cultural background, which might influence their response to power dynamics when balancing accountability and empowerment.

Hernandez (2008) suggested that the CCM utilizes a family paradigm, connects to a larger system perspective, and is inclusive of a multi-cultural lens in the supervisory process. When the supervisee's societal and individual contributions were valued, there

was space for diversity in a multi-professional framework. Specifically, the CCM (Hernandez) addressed families' health in a systemic context by taking into account structural societal issues that create life-threatening situations for those who depend on their social location. The following example illustrates the strengths of a multi-culturally competent supervisor, a core competency area in counselor education programs.

In this example, Hernandez (2008) stressed the positive implications that result when supervisors adequately balance the power dynamics within supervision settings. Hernandez shared a story about a male supervisee who had actively voiced concerns about the interpretations of a term used by other group members in a group supervision session. In a case presentation, members of the group presented on a couple who had been cohabitating for the past 15 years as "roommates." The male supervisee in this example had self-identified as homosexual and sensed heterosexual bias within the supervision group. In this example, the supervisor validated and respected the supervisee's view that the client may be using the term roommate instead of lover because of societal and family views. The supervisor took the lead, acknowledged this viewpoint, and further explored counselor bias; in return, the supervisee felt supported and validated.

#### Generic Supervision

Whereas specific frameworks have been presented, Davies et al. (2004) introduced the term "Generic Supervision" to describe the more practical use of multi-professional clinical supervision. The term supervisory generalist could be used to describe the mental health practitioner practicing in a supervisory capacity in a multi-professional setting. The Multi-Professional Model (MPM) presented by Davies et al.

was developed from a study of a group of mental health practitioners with different skills, training, and professional affiliations.

Davies et al. (2004) stated that the primary purpose of the multi-professional group was “to develop a generic supervision framework capable of encompassing the supervision provision of all members of staff, and to support its implementation” (p. 2). The MPM of supervision by Davies et al. incorporated parts of other supervisory models, such as the IDM (Stoltenberg, McNeill, & Delworth, 1998). The IDM was used as part of the supervision matrix to identify levels of skill, experience, and knowledge. Instead of providing one model of supervising multi-professionals in a mental health setting as previously described, Davies et al. (2004) combined three models to provide one supervisory framework that they suggested would more accurately include the complexity of the supervisory process.

Davies et al. (2004) discussed the strength in knowledge from different perspectives. “Given the range of professionals working in the unit, the supervision provision must meet the needs of individuals with different training and clinical skill” (Davies et al., p. 2). They further described the matrix that allows for unique skills and knowledge to be evaluated by way of measurable inventories that are inclusive of development, professional identity, and include personal supervisory growth. Current research does not accurately represent supervision from a multi-professional perspective but instead from discipline specific and singular approach models (Davies et al.).

Further validity for the MPM of supervision comes from an on-going audit system that tracks supervision provided from external sources, not just those that are internal to the site where the supervision occurred. By using their matrix of measurable clinical and supervision competency areas (20 total) that cover such topics as teamship skills,

theoretical framework, experience, and diversity, a functional supervisee baseline is provided for supervisors in the multi-professional setting. The research of Davies et al. included a study of 55 new staff members from various mental health disciplines who were trained on the matrix and then given the competencies as a self-assessment (2004). The findings validated the initial expectations that overall functional levels closely related to self-evaluation assessments, which also provided supervisors with a skills baseline for multi-disciplined staff.

#### Counselor Education and Supervision and IC

Nelson, Johnson, and Thorngren (2000) discussed the increased need for models of integrated care and suggested a call to action for the counseling field to take responsibility for providing appropriate training at the educational or academic level. Additional articles from the counseling field have suggested the need to have interprofessional collaboration to help reduce tension between the mental health disciplines (Lopez-Baez & Paylo, 2009; Myers et al. 2002). A review of the literature suggests that interprofessional collaborative care is continuing, and yet there is a gap in the research that could increase understanding of counselor competencies within these systems.

Arthur and Russell-Mayhew (2010) discussed the need to prepare counselors adequately for interprofessional collaboration by including additional principles and practices in the supervision and training curriculum. The 2010 commentary is supported with data from international trends on collaborative patient-centered care recommendations. Additional articles have been published that specifically address the training and supervisory needs of mental health clinicians in an integrated setting (Edwards & Patterson, 2006; Enochs, et al. 2006). The following section will outline the

critical need to gain understanding of academic training readiness and supervisory needs as they relate to the counselor who practices in IC settings.

### Academic Training Readiness

#### Counselor Competencies

The standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) guide national requirements and course content for counselor education programs. Since 1981, these standards have helped to establish best practice for the counseling field and continue to influence the graduate level counseling curriculum. CACREP standards are revised every eight years based on current discipline needs and feedback from the professional counseling community (CACREP 2001, 2009, 2016 draft). CACREP (2009) represents the most recent revision of the 2001 standards and covers several disciplines within the counseling family.<sup>1</sup> “The accreditation of a counseling program is in part an affirmation that the program has established conditions and procedures that meet and maintain established standards for the preparation of professional counselors. Accreditation provides a benchmark of program commitments to quality counselor preparation in accordance with established preparation standards.” (CACREP, 2009, p.13)

Marini and Stebnicki (2009) published a guide for the counseling professional that includes contributions from over 100 counseling professionals offering recommendations for practice, continuing education, and collaborative guidelines. Marini and Stebnicki’s book is structured around the most recent CACREP (2009) standards that include eight core knowledge and content areas: 1) professional orientation

---

<sup>1</sup> In September 2012, CACREP released a first draft of the 2016 standards that will replace the 2009 standards currently in use by counseling education programs.

and ethical practice, 2) social and cultural diversity, 3) human growth and development, 4) career development, 5) helping relationships, 6) group work, 7) assessment, and 8) research and program evaluation. According to Marini and Stebnicki, the counseling profession is in an unsettled time with fluctuations related to reimbursement, parity, coursework requirements, and specialty credentials. Adaptation is a necessary function as we are a much different field than the counselor educators of the 1950s-70s (Marini & Stebnicki, 2009). The CACREP standards reflect current practice needs based on comprehensive feedback from those in the field along with health care reforms and changes within the systems of care that influence counselors (Marini & Stebnicki, 2009).

A critical review of the CACREP standards 2001, 2009, and the 2016 draft show an increasing emphasis in the areas of interdisciplinary care, the use of the biopsychosocial model, and wellness initiatives. The standards help to ensure that counselors are being trained in the areas that will be of most value to them and their clients. Studies from other allied health disciplines also reflect a similar change towards medical and interdisciplinary collaboration (Davies, Tennant, Ferguson, & Jones, 2004; Robert et al., 2009; Wals & Schwarzin, 2012).

Whereas there are several graduate specialties that receive accreditation through CACREP (2009) standards, the participants for this study can all be classified within the program category for Clinical Mental Health Counselor at the Master's or Doctoral degree level. When CACREP revised the 2001 standards of best practice in 2009, the label Community Counselor was changed to Clinical Mental Health Counselor. Both the 2001 and 2009 (CACREP) versions include a similar definition for the role of counselor as "one who can work with individuals, families, or groups and is knowledgeable in the principles of prevention, multiculturalism, and developmental life span needs." The 2009



shift from community counselor to clinical mental health counselor suggest an added focus on health and wellness and the change to use of the word clinical could be interpreted with a more medical focus (CACREP, 2009).

There are eight core knowledge areas for best practice found in the 2009 standards. The CACREP standards have provided a foundation for the production of counseling program curriculum as defined by a generative document (Prior, 2003) and can be seen in larger policy documents such as the creation of a professional counselor licensing act. Knowledge and the operation of power define "how things are to be arranged, and what is to be included and excluded in the realm of what is known and what is knowable" (Prior, 2003, p. 47). Knowledge and power are not static constructs and the evaluation of a counseling curriculum using CACREP standards is subject to interpretations and ideas that reflect the culture of the individual program. With the continued inclusion of collaborative care within these standards, it is unknown how individual CACREP programs have adapted and responded and how relevant the academic coursework is training counselors for this changing workplace environment.

#### Integrated Settings

Aitken and Curtis (2004) recommended several integrated settings with which counseling interns should become familiar and suggested a continued link between counselor educators and integrated health practices. Mellin, Hunt, and Nichols (2011) suggested the need for models of practice that will help to incorporate systemic issues and help develop counselor identity within the context of interprofessional collaboration to address client and social concerns. Mellin et al. conducted a qualitative study from the feedback of 238 professional counselors and suggested a "shift from individual counseling to using individual-in-environment perspectives" (p. 146).

In a 2002 survey of seventy-one leaders from the counseling field, a majority reported participating with other professional groups in areas that would help to support advocacy in legislation for client issues (Myers, Sweeney, & White). The two areas that were highlighted included aspects of client care through managed care companies and the need to develop a helping profession that is unified. Myers et al. suggested that models of advocacy in the area of interprofessional alliance are needed.

### Counselor Supervision in IC Settings

The following section will present an overview of the recent trends in supervision offered within interprofessional collaborative settings. It will be crucial for supervisors to have structured standards to increase their understanding of their role in the training process across disciplines. A review of the literature highlights complex demands on supervisors immersed in collaborative or integrated care settings. Suggested areas of improvement include: the need for a specific framework for the supervision process, support for supervisory generalists, and practice strategies that could be implemented for multi-professional supervisors.

As Nelson et al. (2000) illustrated, accreditation standards and ethical guidelines stipulate that university program faculty should provide professional development opportunities for site supervisors, including training in supervision. Nelson et al. suggested that it is incumbent upon university faculty to understand the professional needs of mental health counselor supervisors and to provide effective training to meet those needs. The reality is that mental health settings may limit supervisory options to a single person who, in any given setting, could supervise counselors, social workers, marriage and family therapists, psychologists, and medical professionals (Nelson et al.).

Nelson et al. (2000) supported the use of a developmental model for supervision stressing that the experiential aspect of change is part of the development that the counselor goes through in multi-professional team settings. The authors also considered an integrated model that would provide guidelines for mental health supervisors and suggested a "call to action" for university counseling program faculty to take responsibility to ensure that supervision is taught and addressed. Although this call to action is discipline specific, counselors themselves would need to receive multi-professional training.

#### Identity Development Model

As earlier presented, Davies et al. (2004) included the developmental model as part of their overall assessment to improve supervision in a multi-disciplinary medical team. Stoltenberg and Delworth's model (1987) is most often used within the counseling field as a developmental model of supervision and that helps to identify between novice, intermediate, and advanced clinical competencies. In relation to supervisees' practice in alternative healthcare settings, Tracey, Ellickson, and Sherry (1989) lent validity to IDM by presenting qualitative research that showed that, when a novice supervisee experienced anxiety over a client situation, they preferred more structured supervision that was domain-specific, while a more experienced clinician preferred unstructured supervision with content-specific areas producing little to no anxiety. An example might be of a less experienced counselor who is dealing with a client crisis that is causing increased anxiety who would benefit from more structured supervision. In contrast, an experienced mental health practitioner might prefer more flexible supervision with more autonomy and creativity.

## Supervision Framework

A review of the literature related to supervisory models utilized in interprofessional collaborative settings is scarce across disciplines. Although there have been several supervisory guides, such as Scaife (2003), Hawkins and Shohet (2000), Baird (2008), and Degeneffe (2006), they provide a more broad-based approach for human service professionals across disciplines. There seems to be a lack of a leading framework to train mental health practitioners to become supervisors working in interprofessional settings. A multi-systemic framework calls for supervisors who are adequately prepared with both the skills and the knowledge that will allow them to have confidence in working in a new era of care.

To understand better the needs of counselors practicing in these complex environments, Smythe, MacCulloch, and Charmley (2009) suggested the need to first define supervision from the counselor's perspective before rationalizing how the supervision should be provided. Few studies from the counseling field have provided clarity regarding a preferred framework for training supervisors for IC settings; research from the allied health fields have, by contrast, presented options such as Davies et al., (2004) and Hernandez (2008).

Smythe et al. (2009) suggested that wisdom in supervision means achieving what has been defined as supervision (the framework) and also providing a rationale for how to deliver that supervision (the implementation). Counselor educators play an integral role in helping to prepare future practitioners to enter the changing mental health field that will be influenced by disciplines other than their own.

## Ethical Considerations

Sutter, McPherson, and Geeseman (2002) discussed the importance of supervisory relationships within the IC setting as the trend continues to place psychologists in direct supervisory arrangements with other mental health clinicians. Sutter et al. pointed to the importance of establishing a supervisory contract to outline the quality of care expected, practice issues, and adherence to ethical standards. In a collaborative setting, a supervisor will be influenced by his or her ethical standards even though his/her own scope of practice may be different from that of his/her supervisee (Sutter et al.).

### Counselor Perspectives of IC

In reviewing the literature on interprofessional collaborative care, the research has been presented from the larger landscape of the allied health fields as well as the more individual discipline perspective. Another way to view IC would be through a systemic paradigm, to include both emic and etic perspectives. In Agnello's 2001 account of the individuals' experience in a changing workplace, the ideas of an emic-etic balance are useful to help understand the impact of change on self-identities.

According to Agnello (2001), an emic perspective would describe the behavior or a belief in terms of meaning for the person within the culture of the individual in environment. An emic account would focus on the development of the counseling professional within the context of interprofessional collaboration. An etic perspective would encompass the ecology of the phenomenon we want to understand better (Agnello) in this case, integrated mental health care. The emic view would encompass the individual meaning provided by the professionals within this ecology while an etic view would account for the behavior or beliefs of an observer who is attempting to be culturally neutral.

### An Emic Perspective

Studies such as Wals and Schwarzin (2012) favored a qualitative approach with the researcher as a reflexive learner, a type of collective learning that is trans-boundary, trans-discipline, and trans-perspective so as to not be defined by one discipline. Attempting the same perspective, this study utilized a qualitative research design in an attempt to better understand how participants functioned in their environments. Data collected from in-depth interviews provided the emic perspective in relation to individual roles and perceived value as part of a bigger IC care setting. This shift from individual to individual in an environment is reflected in other studies from the field (Mellin et al., 2011; Scott, 2010).

### Counselor Lived Experiences

Loftus (2009) studied health care professionals and suggested the need for more naturalistic designs to study their professional culture and meaning. In 2010 Loftus and Higgs used an interdisciplinary research approach to study participant perceptions of their environment. Hermeneutic phenomenology “the study of the interpretations people make of their experiences” (Loftus & Higgs, 2010, p. 382) was used to examine professional culture and meaning.

In a 2011 survey from 238 licensed professional counselors, Mellin, et al. attempted to better understand how they distinguished the professions of counseling, social work, and psychology. This qualitative design revealed that counselors viewed social workers as systemic in focus while identifying themselves as oriented towards prevention, development, and wellness, and they viewed systemic collaboration as being beyond their scope of practice. Results suggested a shift from “individual counseling to using individual-in-environment perspectives” (p. 146).

While the emphasis in the research of counselor lived experiences has primarily been placed on how to provide an integrated mental and medical health care team, there is a lack of research that provides insight from the counselor's perspective when it relates to communication about health care decisions. Studies such as Thomasgard, et al. (2004) reported barriers to collaboration and cited the need for a collective structure to help guide these multi-professionals.

#### Etic Perspective

Multicultural theories, as presented in Sue and Sue (2008) and Goodman et al. (2004), highlight ideas of shared power and collaborative efforts, where emphasis is placed on the collective whole rather than on the individual. This shift from individualism to systemic involvement is echoed in Family Systems Theory and the Ecological model as presented by Bronfenbrenner (1979).

As we move to a new era in mental health delivery, the question becomes: How are current voices from the field being heard? Hansen (2010) suggests a theoretical shift that would challenge the current conflicting messages that are present in the counseling profession regarding professional identity. Hansen makes an interesting point that while the counseling field strives for diversity within the framework of multiculturalism, the field standards, as evidenced by CACREP (2009), place importance on the faculty having degrees in counselor education with a counseling professional identity.

Goodman et al. (2004) draws a distinction between being a co-learner and an expert, suggesting that co-learning allows one to truly integrate and move beyond simply being an expert in one's field. If multiple disciplines are involved in the collaborative process to improve access for mental health needs, there should be multiple voices discussing how a multi-systemic health care system should operate. The formation of

professional organizations such as the Collaborative Family Healthcare Association serves as an advancement of a more integrated movement<sup>2</sup>

A predominant number of related research studies in the field of counselor education have followed a qualitative methodology in an attempt to understand better the meaning that people give to their lived experiences. In-depth interviews, such as Harris' work (2009) with school counselors or Malin and Morrow's analysis (2007) of 26 members of an integrated team, have concluded that there is a need for a more systemic collaborative identity that could have a more positive client impact. Malin and Morrow define this identity as a trans-disciplinary approach that would “encourage professionals to work together under common aims and systems, regardless of their discipline or status” (p. 453).

Additional articles from the counseling field have suggested a need to have interprofessional collaboration to help reduce tension between the mental health disciplines (Myers et al., 2002) and to provide advocacy that requires cross-systemic collaboration (Lopez-Baez & Paylo, 2009). Aitken and Curtis (2004) presented an integrated care model as an emerging trend, yet substantive empirical research that supports this model is already present in many other mental health disciplines.

This call to action, echoed in much of the counseling literature, lacks research on how to help support the development of a new interprofessional counselor who will be a critical piece of the new mental health IC care delivery team. A more informed understanding of how to set this education and training in motion could help to identify aspects of a counselor's cultural context from an emic view. By hearing from multiple

---

<sup>2</sup> It is interesting to note that that the organization chose the word collaborative rather than the word integrated to identify themselves.



perspectives and their rich descriptions of their lived experiences, this study, provides the missing piece that is needed to expand our knowledge of how to support individuals from an ecological perspective.

### Summary and Conclusions

Appelbaum and Gandell (2003) stressed the importance of collaboration for the future improvement of health and mental health care delivery, a message that is found throughout the literature and referenced in Chapter 2. With the projected increase in mental health spending, the reduction of resources and the need to provide fewer barriers for those seeking help, the counseling profession will need to adequately prepare and support advancing integrative needs. As the counseling profession struggles with its own professional identity, counseling interns and Licensed Professional Counselor Associates are increasingly being placed in this new mental healthcare environment.

In summary, the literature review highlights a lack of consensus as to what constitutes interprofessional competencies and a lack of research from the counselor education and supervision field as compared with other disciplines that currently practice within these settings. This review validates the dearth of knowledge as related to counselor training and supervision within interprofessional collaborative settings and draws attention to the need to know and understand more about how best to train and supervise counselors from the lived experiences of counselors currently involved in providing care within this framework. Now that the need has been expressed, the following chapter will outline the proposed methodology used to understand the workplace experiences of mental health counselors as related to their academic readiness and supervisory support in interprofessional collaborative care settings.

## CHAPTER 3: METHODOLOGY

### Author Note

My professional journey began in 1997 when I started my clinical work as part of a newly created internship in Medical Family Therapy (MFT). I was part of a movement originally influenced by Engels in the 1970s, called the biopsychosocial model of care. In this setting, mental health clinicians worked alongside other providers as part of a treatment team for outpatient triage, group supervision, and couples therapy. The treatment team consisted of my direct supervisor, a Ph.D., Licensed Marriage and Family Therapist (LMFT) and an M.D. Psychiatrist, as well as other MFTs, a fellow MFT intern, several Psychiatric medical residents, and some second and third year medical students who would rotate about every six weeks. For one year, I followed the medical students and residents through clinical rotations, received training in psychiatric and substance abuse assessments, psychopharmacology, documentation requirements, assisted in research coding, and even observed several rounds of shock treatment. Almost all of my clinical sessions and psychiatric assessments were conducted with live supervision behind a one-way mirror. In post-graduate school, I worked with children who had witnessed violence in the home or who had been the victims themselves of physical, mental, or sexual abuse. From the basement of a domestic violence shelter, I provided clinical support for women and their children who had fled for safety. I learned that psychological assessments look completely different when someone is just trying to get their basic needs met.

For eight years, I worked in the non-profit sector, where funding was diversified between grants, private pay, a sliding scale, and fundraising. My progression from site, regional, and business development director with the same non-profit came at a time when the mental health system was going through a divesture process. I remember sitting through multiple information sessions for this new change in care delivery that would require all billing and documentation oversight for clients in the public mental health system to funnel through new Local Management Entities (LMEs). At that time, we were being told that this new system would streamline the Medicaid process and that the quality of care would improve. Economic troubles were persistent, and soon, changes began to impact service delivery across the care continuum, with reduced funding. There were people with mental health needs such as, depression, anxiety, and family crisis, with few provider options and a six-month wait for medication consults with a psychiatrist.

Writing and proposing grants became a larger part of my job responsibilities. I pushed to have our agency become a Medicaid provider as the insured population in the mental health care system decreased and so did non-profit funding for programs affecting people with the greatest need in our community. At the same time, many local employers increased their employee insurance copays with decreasing health care coverage. Some insurance companies closed their behavioral health networks, creating an increase of out-of-network providers. If a provider was out-of-network the client could be charged a different deductible, and in most cases, a disproportionately higher one. In private practice, I have seen first-hand how health care reform has led to increased co-pays, deductibles, and created incentives for medical care teams to become a one-stop shop.

## Introduction

The purpose of this research study was to understand the experiences of mental health care delivery within an interdisciplinary collaborative setting from the perspective of professional counselors working in these environments. Based on critical needs highlighted in the counseling literature, this inquiry focused on academic readiness and supervisory support. The new knowledge gained from this study will provide research where none presently exists to help inform counselor educators and supervisors about best practices in the current system of care.

## Research Questions

- 1) What workplace factors influence counselors who practice in interprofessional settings?
- 2) How does academic training readiness impact counselors working in IC settings?
- 3) What are the supervisory needs of counselors working within IC environments?

## Research Methodology

A Phenomenological Analysis informed this research design. A hermeneutic phenomenological approach is the study of the interpretation people make of their experience (Loftus & Higgs, 2010). This approach seeks to better understand the essence of a phenomenon by studying individual experiences and how these experiences inform the meaning of the phenomenon (Moustakas, 1994). The foundation of phenomenological inquiry comes from the theoretical perspective of social constructionism, where knowledge is relative to the context of the phenomenon; therefore accounts are relative to the interpretations of experiences (Hays & Wood, 2011). In this

approach, the researcher is not separate from the phenomenon with a more reciprocal quest for understanding and a less hierarchical relationship.

In search of an increased understanding of the phenomenon through participant meaning, several qualitative methodologies could be used such as interviews, group observation, or personal essays. The importance would come from the descriptions provided, in whatever form the researcher chooses, with the intent to solicit participant experiences (Hays & Wood, 2011). A phenomenological study asks questions to get at the meaning as defined by the participants. These questions lead to a rich description of the phenomenon that is analyzed by a reciprocal process of reflection and interpretation, where the researcher is part of the instrument of inquiry (Hays & Wood; Sprenkle & Moon, 1996). The meaning of the phenomenon can then be derived from the constructed accounts of all involved.

#### Justification for the Use of Phenomenological Analysis

The rich description obtained during in-depth interviews is consistent with a phenomenological approach. To understand better a participant's account of his or her lived experiences as part of an interprofessional team, the researcher intentionally interviewed counselors in similar settings. Consistent with qualitative inquiry, the researcher used narratives to bracket expectations prior to data collection.

#### Systemic Theoretical Framework

This study was framed within the General Systems Theory. Ludwig von Bertalanffy developed what we know today as General Systems Theory, although his original terminology was "teachings" it was modified during translation from German into English and changed to "theory" (Nichols & Schwartz, 1995). A constructivist, he

identified as a generalist and shared his teachings across many disciplines--a true an interprofessional pioneer.

A systemic view of interprofessional collaboration might shift focus from an individual to an individual in his or her environment. This systemic lens for multi-disciplinary settings is reflected in other studies from the field (Mellin, et al., 2011; Scott, 2010; Wals & Schwarzin, 2012). Counselors may describe their experience from an emic view (their role in a system where they feel that they have no voice and no power and are just "one small piece of the puzzle") and also describe their cultural experience in the context of an etic view (ideas of inequity in the system and the economics driving mental and health care decisions).

An ecological paradigm would include both emic and etic perspectives, where emic describes the behavior or a belief in terms of meaning for the person within the culture and etic is an account for behavior or beliefs by an observer in an attempt to be culturally neutral. The etic view would encompass the ecology of the phenomenon we want to understand better, in this case, interprofessional collaboration. The emic view would encompass the individual meaning provided by the professionals within this ecology.

The emic view of ecology, or the individual in his or her environment, allows for the development of a professional identity within the context of interprofessional collaboration in order to address his or her social concerns. Consistent with the theoretical foundation of the study, a systemic framework is one that is ever changing and is influenced by all that it connects (Wilbur, 1998). Scott (2010) discussed the idea of transcending and including as related to our self-concept, where we begin to see

ourselves as more relational beings, and are directly influenced by what he calls “intersubjective knowing”--an active relationship with others. Scott’s concept of intersubjective knowing informs how we make meaning and define our environment, and is crucial for integrated environments.

## Research Procedures

### Sampling and Location

A purposive, snowball sample was utilized to recruit professional counseling participants in the southeastern United States who were practicing within an interprofessional collaborative setting as operationally defined in Chapter 1. Inclusion criteria included licensed counselors and associate licensed counseling professionals from an IC setting that included at least four professionals as previously defined, with at least one of the four team members representing the medical profession, non-specific to the mental health field. In addition, every effort was made along the way to select a stratified sample of participants in an attempt to be diverse in terms of age, gender, ethnicity, and level of experience.

Recruitment letters were emailed to CABHAs in the southeastern region of the US utilizing a snowball approach to gain participation. The initial recruitment site was a location familiar to the researcher and identified as having a large number of potential participants who fit the criteria for selection in the study. Research sites were based on participant selection. Geographical limitations were used to reduce travel costs and increase the opportunity for in-person interviews. All potential counselor participants received a brief telephone screening and disclosure statement prior to participation in the study. Counseling participants functioned as part of a collaborative interprofessional

environment, with a collective goal to improve the integration of behavioral and biomedical health. All efforts were made to conduct interviews in-person, and in cases where this was not possible, phone interviews were conducted.

The sample included 10 counselors with every effort made towards possible concerns for confidentiality as well as preference for interview location. All participants were clinicians who were licensed as professional counselors (LPC) or licensed professional counselor associates (LPCA) in the state in which the research was conducted. In addition, participants graduated from a CACREP accredited graduate program. The participants were informed of the nature of the study in the beginning, including the disclosure of the researcher as part of the instrument used to observe and identify themes.

Participants were limited to those who represented the counseling discipline so that findings could be practically applied based on disciplinary similarities. Although this study is discipline specific, it is hoped that it could be replicated for similar interprofessional teams and disciplines. Certain demographic data was excluded or grouped together in order to reduce any identifiable information.

#### Aggregate Descriptions

There were 10 participants recruited for this study. Seven were female and three male; one identified as African American, two as bi-racial, and the remaining seven as Caucasian. Half of the participants fell within the 35-39 year old age range, with two between the ages of 40-44, one in the 30-34, one in the 45-49, and one in the 50-54 age range. Seven participants had their LPC, three their LPCA, two had additional licensures, and only one had an LPCS. Of the 10, three had their doctoral degrees and



seven held a Master's degree. When asked about their current roles, four identified as therapists, three as clinical supervisors, three as counselor educators, two as team leads, one as a school counselor, one as an administrator, and one as a counselor.

### Design

The study utilized a semi-structured in-depth interview design. Individual 60-minute interviews were conducted with each participant using open-ended questioning from a semi-structured interview guide. The interview guide is included in Appendix C and incorporates themes from the main research questions. Interviews were conducted to gather information about how participants assign meaning to their experience in an interprofessional collaborative setting relative to academic readiness and supervisor support. The researcher and one independent coder, familiar with qualitative inquiry, audited the content of each interview and identified common patterns.

### Interview Purpose and Researcher's Role

According to Kvale and Brinkmann (2009), the use of interviews for research purposes versus other options is that the research interview is knowledge producing through professional conversations. The authors place emphasis on the interactive process between the interviewer and interviewee to learn more about a phenomenon. The researcher will take on the role as a co-learner, where the communication that unfolds is mutually influenced by the response from both the participant and the interviewer (Goodman et al., 2004). The purpose of the interview was to provide a better understanding of the layers of influence for clinical mental health care as conceptualized by those currently familiar with its practical use.

In-depth interviews are generally used to better understand the cultural context of

the professional in an interprofessional collaborative setting (Harris, 2009). An interview can give voice to those most deeply entrenched in a setting. Multicultural theories, as presented in Sue and Sue (2008) and Goodman et al. (2004), highlight the idea of shared power and collaborative efforts, concepts that fit well within an interview where individuals are given the power to communicate their ideas.

Whereas, there are different forms of interviews such as therapeutic and journalistic, the research interview can be a collaborative process to improve and inform change (Rossman & Rallis, 2012). An interview guide was utilized as a framework with a set of questions considered as semi-structured or guided (Rossman & Rallis).

#### Interview Guide

Example of an introductory statement to a participant: “Two years ago the American Disability Act of 2010 led to the restructuring of the mental health delivery system. Some of those changes have direct impact on the type of agency that you work for. Your experience as a provider in this new health care environment may allow for insight that could be valuable to increase understanding of what is needed to support counselors entering the field and implications for improving mental health delivery.”

#### Informed Consent

Participants were informed of the data collection and storage plans prior to the taping. Disclosure was made during the informed consent process pertaining to the limits of confidentiality. Transcriptions and voice recordings were stored on a password protected personal computer and stored in a confidential secured manner. At the conclusion of the study all data with identifying information was erased.

## Data Collection

Data collection began with participants who were recruited with a purposive sampling method as detailed in the research procedures. The researcher made preliminary contact with each participant by phone to screen for the criterion requirements (being a licensed LPC or LPCA and current participation in a work environment that fits the operational definition of an interprofessional collaborative setting). The initial phone contact included a disclosure statement, confirmation of the location and time and date for the in-person or phone interview, and addressed any additional requirements. The sample screening questionnaire is included in Appendix A.

Upon completion of the screening, the researcher followed-up with the scheduled in-person or phone appointment with the participant at the agreed upon meeting place or by phone if an in-person meeting was a hardship. Prior to conducting the interview, the participant was given the informed consent form, including requirements for audio-taping the interview, to read and sign. The 60-minute semi-structured in-depth interviews were audio-recorded and followed the interview guide protocol, included in Appendix C.

A field note journal was utilized throughout the process for a subjective account of the research process. Notes were taken prior to the interview and during the interview, as well as upon reflection post-interview. This reflective journal was also helpful to determine the effectiveness of the interview guide and inform changes that needed to occur prior to meeting with the next participant. Communication during the individual interviews was guided by the initial research questions, with flexibility for change as needed.

## Reflecting

Upon completion of each interview, the researcher transcribed the audio recordings. Following each interview, the participant was sent a typed copy of the transcript by email, including a cover sheet with instruction for providing additional comments/feedback, also known as auditing. The participant was given instructions to read through the transcribed interview and make any notes in the margins if he/she felt something was misrepresented or if additional clarifications needed to be made.

This process of auditing by participant reflection is consistent with qualitative designs and helps to ensure an additional layer of integrity by including recursive feedback. The participants were provided one week to return transcripts via email or mail. Participants were given instructions that if the transcripts were not returned within the week provided, the researcher would note that no changes were made by the participant to the interview transcript.

Originally, the aim for participant involvement in this study was 12-15 individuals. However, the researcher and the independent coder mutually came to the decision that adequate saturation had been met after the tenth participant interview, based on the lack of new themes. Data entry included field notes and transcribed interviews. Information was entered into a spreadsheet, with columns representing organization of data points, themes and categories, which were then coded in the same manner for consistency. The independent coder reviewed the same information on his or her own and used a separate spreadsheet to list categories and themes. Data analysis occurred along the way by the researcher and the independent coder.

## Data Analysis

The data collected represented the examination of multiple sources of information obtained from the participant, the researcher, and an independent coder. The data was sorted and categorized utilizing selective coding identified by data points, themes, and categories within a matrix framework where columns and rows represented interrelatedness between the data. Integrating the information across participants helped to create a group composite.

The interview report followed the Ad Hoc techniques presented in Kvale and Brinkman (2009) for interview analysis. The specific strategy used is detailed below followed by a table that illustrates the organization of the data and the interpretations of the categorical findings.

1. As a first step to analyzing the data, I reviewed the typed transcripts then listened again to the audio recordings to check for accuracy. The transcripts were printed out with large-size margins and separated and numbered by a line of text. During the initial run-through, I underlined repetitive words and boxed words that seemed to be impact words or phrases that repeated throughout the text regardless of the question being asked. This bricolage approach helped to provide less structure to move from concrete and descriptive to more abstract and exploratory.
2. The second step of analyzing the data involved rereading the transcript and making notes in the margin and also within the text following my questions to the participants. I differentiated three clusters of data: left margin, in-text, and right margin. The left margin focused on codes in the text with more concrete areas such as participant defines integrated health. The in-text comments related to any

underlined or boxed words or phrases in the text. An example of an in-text code would be words such as supervision, collaborative care, or internship, all of which could be related to the same idea. Therefore, even though one participant used the word internship several times throughout the interview, in reviewing the transcript the word internship could have related to supervision and also could have been related to training. In this example, the in-text comments could be related to more than one area. The last cluster of data was identified using the right margin in the transcript and were more abstract ideas that were identified based on patterns that were seen throughout the text. An example of a more abstract idea that would have been identified in the right-hand margin of the transcript would be a reflection of changes in the system or include broader concepts such as isolation.

3. The third step involved beginning to make contrasts and comparisons, initially only within the same participant data, and then later across all 10 participants. During the comparisons between participants I would make notes for any areas that seemed to be related to ideas from another interview and could be part of a larger theme or category. At this point I began creating a worksheet with cells to represent these similar themes and ideas that were being identified. Along the way, the independent coder followed the same guidelines making steps one through three as well as creating a unique work spreadsheet (separate from the one created by the researcher) for themes and ideas that were identified.
4. Following the three clusters of data, I began to merge some ideas and categorical buckets comparing the larger groups to the original questions and overall purpose

of the study. I also went back to compare findings to the initial purpose and scope of the research to the data that was being identified.

5. Some ideas were initially described as a perspective that was unique to the individual participant without relating specifically to other responses. These perspectives seemed related to that person's background and history within the mental health system. While there were common themes and categories related to educational competencies and supervisory support, there were also areas that were unique to some individuals that may not have been compared or contrasted with other participant data. A matrix is included for both identified emic and etic perspectives in Chapter Four.

#### Verification of Interpretation

Verification standards were employed to increase trustworthiness, applicability, and consistency in the study. Multiple sources of collection through interviews, field notes, and a reflexive journal were used to triangulate the data. Peer debriefings and rich descriptions given by the participants throughout the study also increase verification standards. A reflexive journal included a subjective account of the research process as well as helped to determine changes that were needed during the data collection process.

Member checking was included throughout the study to add an additional layer of trustworthiness. Participants were provided time to review their transcribed interviews and provide recursive feedback following each interview. One non-participant, familiar with the field, reviewed the transcripts independently and identified categories and themes. This independent coder helped to ensure consistency in the collection and coding of data and served as an auditor for the study, including the completion of an audit

trail. The researcher also brought prior experience of interprofessional collaboration to help increase trust among the participants of the study. Finally, the independent coder was familiar with qualitative analysis and worked in a CABHA agency (not affiliated with this study) and, therefore, was familiar with IC terminology.

### Summary

The field of counselor education lacks a presence in the collaborative research field and, yet, counselors continue to be part of this environment during internship, practicum, associate, and licensure status. It is incumbent on us as a field to listen to the voices of these counseling professionals and understand how they make sense of their role in this setting. The following chapter will detail findings from participant's rich descriptions of their experiences working within these interprofessional collaborative care environments.



## CHAPTER 4: THE LIVED EXPERIENCES OF COUNSELORS

### Introduction

The purpose of this study was to develop an understanding of the perspectives of counselors who practice in interprofessional collaborative care settings, in relation to academic training readiness and supervisory needs. Based on participant interviews with 10 counselors, the following questions were answered: What workplace factors influence counselors who practice in interprofessional settings? How does academic training readiness impact counselors working in IC settings? What are the supervisory needs of counselors working within IC environments?

The ecological paradigm provides a framework to help organize the presentation of the data in Chapter Four. Emic perspectives will be presented for each participant that provides individual meaning from the counselors within the context of their IC environment. Each participant's rich description includes a visual summary of the key words, phrases, and ideas that were coded. Emic perspectives will be organized with an introduction and brief background on the participant, a description of the identified codes, including examples from the participant transcript, followed by the main category, capturing the essence of the individual counselor experience. Each participant perspective will conclude with a visual representation of the main ideas. A composite account from the etic perspective will follow that includes universal themes across all participants that help to provide a better understanding of the experience of working within an interprofessional collaborative care setting. This composite synthesis of the

larger group themes will aid in etic perceptions of the individual, the discipline, and the larger practice culture. Chapter Four concludes with a brief summary of the major findings.

### Emic Perspectives

#### Participant One

Participant One shared his expertise from twenty years post-licensure experience as a therapist, clinical supervisor, and counselor educator. He has provided clinical care in both a school and outpatient setting and considered his work collaborative in nature.

The collaborative care team that he identified working with included school nurses, psychiatrists, psychologist, social workers, counselors, marriage and family therapists, school counselors, substance abuse professionals, law enforcement officers, a school resource officer, and social service staff.

#### Communication Boundaries

Participant One presented the idea that the style of communication used among team members had the potential to create communication boundaries within the team and ultimately could create divisions across disciplines. As Participant One described his experiences working with multidisciplinary treatment teams, he felt that it was how he spoke and communicated to team members from other disciplines that ultimately helped to improve the care that the patients were provided. In the following example, Participant One describes an IC communication style that he has developed over the years that has served him well when collaborating with staff from disciplines other than his own:

One rule is "Always advance the story;" "Don't negate the story." Don't start the narrative that "I don't agree with." So, I never say, "I don't agree with you." I

say, "And this is going on too and underneath you are describing." So I advance the story and make the story richer by calling more people into play for a more complex but rich description. . . .The second part is shine the spotlight on someone else. .It's a good idea, so it helps build the relationship and shows you appreciate them.

In this quote, Participant One described how he adapted his own style of communicating with other team members using communication skills learned in improvisational theatre. When he intentionally included other team member's perspectives as part of a continued treatment plan dialogue, he learned to break down some of the boundaries that occur when everyone only communicates from a one-perspective lens. Ultimately, he found that by valuing others' individual perspectives, there was less division among the different disciplines represented on the team.

Another component related to "communication boundaries" within the team was identified as divergent roles. Team members sometimes functioned in more than one contrasting role, such as supervisor, peer, or advocate. The following quote provides an example of Participant One's ability to separate his roles as a supervisor and peer. When asked if he thought that some people on the teams were not using their voice as they should, he replied:

Yes, it comes up in my supervision all the time, but if I'm on their team, it's their problem. It's their responsibility. People need to speak up.

In his role as a peer on the team, he realized the importance of an individual's independent responsibility to voice his or her own needs. In contrast, he also described that, in his role as a clinical supervisor, he has to remind his supervisees of the need to

speak up and make sure that they are advocating for their client. While this participant is a seasoned counselor and supervisor, a less-experienced clinician may experience difficulty in navigating divergent roles. The following quote provides insight from Participant One's experience about learning how to navigate the different roles needed for a multidisciplinary team environment:

I feel very well-trained. My early supervisors always emphasized interventions at all levels. So you need as many, if not more, interventions for the treatment context as the treatment for the patient. I learned to talk about it in staffings early on in my training program about how staff responds and how staff interaction is diagnostic.

In this example, Participant One's own training for IC care included the encouragement to use his voice as a peer on the team and being taught to see multiple disciplinary responses to treatment care. In this case, the counselor is not only taking on the role of advocate for the client, his client, but the team's client. This inclusive perspective of team care seemed to focus more on respect for disciplinary skills, and, in the description of his training program, provided for positive communication with less division across the disciplines on the team.

#### Negative Team Experiences

Participant One referenced the term "turf" several times during the interview as a negative expression of the disciplinary divisions that can occur when team members attempt to protect their own professional self-interests. The term "turf" provided a backdrop to understanding the dynamics of the team members and how they provided less than positive interactions while attempting to work collectively for the shared care of

the clients they served.

The strength of a team member's ego, or confidence within their value and knowledge that their discipline brings to the team, can sometimes lead to further division between the disciplines. Participant One's belief was that, if professionals, regardless of their professional affiliation, are confident in their own abilities, there is reason to believe that they will be more likely to function in an interdisciplinary way. Participant One provides this insight that someone with a strong disciplinary ego will most likely also have more openness to respect other professionals, providing for a more positive overall experience and, therefore, leading to a more cohesive team with fewer divisions.

The following quote illustrates Participant One's ideas related to these ideas of negative team experiences that include ego strength and turfs:

Well, there are always pockets that are interdisciplinary, and there are always more pockets that are turfish and, to me, well, I guess it has more to do with ego strength or self-esteem of the clinical staff. Because if you are secure you're not even trying to be a smart person. You realize in a multidisciplinary staffing you know everyone's talking about the same thing, from a different perspective, but it's the same thing.

#### Multi-disciplinary Divides

Based on the data from Participant One, multi-disciplinary divides was the main identified category, supported by the codes "communication boundaries" and "negative team experiences". Participant One's varied experience working with IC treatment teams seemed to create an awareness of communication among those with different disciplinary backgrounds. In many cases he learned to navigate a multi-disciplinary system where

communication styles and team roles often had negative consequences in the workplace. Divisions based on disciplinary backgrounds seemed heavily influenced by both communication and team experiences. As Participant One discussed his view on the workplace setting, division's seemed to occur often, ultimately impacting collaborative efforts and client care.

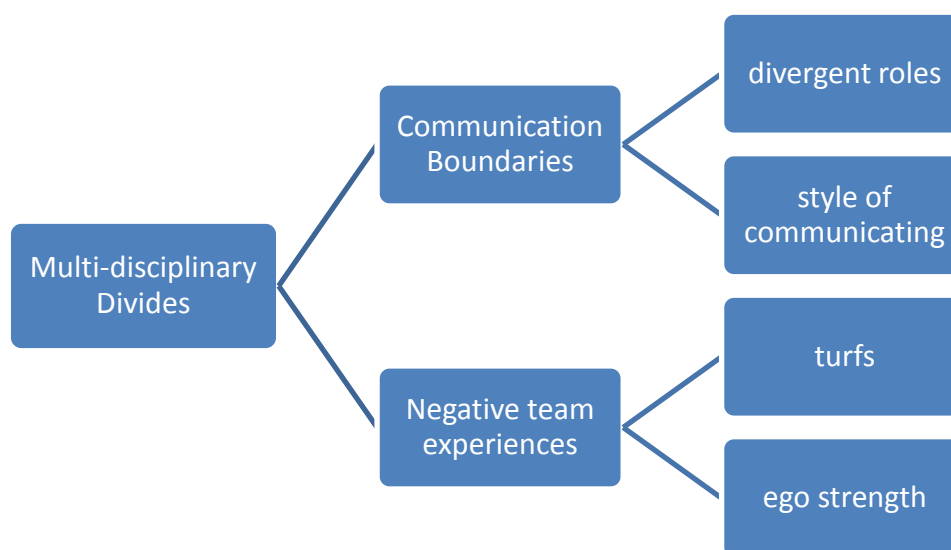


Figure 1: Summary of findings for Participant One

#### Participant Two

Participant Two, who professionally identified as a psychotherapist, holds an advanced degree and has over 10 years of clinical experience. He currently functions in several roles as a psychotherapist, clinical supervisor, and as a counselor educator. He identified his collaborative care team as having professionals from the following disciplines: medical physicians (psychiatrist and family physician), psychologists, nurse practitioners, social workers, LPCs, LPAs, and qualified professionals.

### Value Hierarchy

Participant Two referenced the medical model as the foundation for collaborative care that was expected regardless of disciplinary background. This definition placed higher value on medical providers as the ultimate decision makers of the plan for client care. From this perspective, the value of a team member is influenced by a medical model philosophy that creates membership roles on the team based on credentials and educational background, identified here as a “value hierarchy”. When asked to describe his practice environment, Participant Two shared the following thoughts:

I would say nerve racking, frustrating. Getting people from other disciplines to see things in a way that you see them or getting them to see them in a different way, to be more open-minded especially working with family practitioners or psychiatrists and getting them to see outside the medical model.

Participant Two discussed the idea that any practice environment would have a foundation linked with a particular theory. This philosophy was presented in contrast to what counselors learn during their academic training, typically a more humanistic model with an emphasis on developmental theory. The use of symptom-based measurements, a reference to medication management, and the use of an M.D. who typically leads group supervision and treatment team meetings, were additional evidence that the medical model was the preferred framework in this IC care setting.

Another component related to the value of the IC counselor was a hierarchy based on the team members’ education and credentials. Certain academic credentials or education afforded IC counselors greater respect within the IC treatment team. Based on the previous discussion on the medical model philosophy, Participant Two referenced a

hierarchy that placed the medical physicians at the top as the ultimate team decision makers. During case staffings and meetings, there was a perceived difference in the level of respect and decision making that was afforded this level of responsibility. Participant Two shared his thoughts on how this experience influenced his perceived value within the integrated environment:

Well, in my experience, I have been one of the highest qualified individuals so usually my experience has been more of a pleasant one, more of a collaborative one. . . .The other piece is related to the state and the powers that make financial decisions.. This they base on credentials and how many years of experience you have. . . .As a Ph.D. clinician, you may be seen as the same as Master's level, according to how the state defines the roles and responsibilities based on your credentials.

#### Ongoing Counselor Support

The second code of "ongoing counselor support," included one component that was related to the lack of training offered in IC care. This dimension included specific recommendations for coursework that exposed students to practice environments where different disciplines would need to work together. More than once throughout the interview, Participant Two returned to the idea that, to better provide support and prepare counselors, counseling programs should understand the current working environment. The following is a portion of the interview where Participant Two is discussing his perspective on this idea:

Having professors being able to speak to what the expectations are (in IC settings) as they just seem too far removed from what is really going on and the reality of



the way the system is working right now; they just don't know. They know that big things are happening, but they don't know what they are. I've been invited twice to speak to this, but it has never been followed through.

Another area related to "ongoing counselor support" is the lack of post-licensure supervision. Participant Two described his own experience post-licensure and shared that, the more credentials you have and the more supervisory responsibilities you are given, the less individual support you seem to receive. Participant Two said that he was not receiving regular support for peer or group supervision. While he was a clinical supervisor and licensed as an LPCS, there were no clinical colleagues who matched his level of expertise.

These experiences of lack of support from academic programs and lack of support provided to those with higher credentials highlight a breakdown between education/training and the work environment. As related to academic and professional development of new and seasoned counselors, this lack of support perpetuates further disciplinary isolation. Based on the information provided in the interview with Participant Two, the two main influencers for counselors are typically the team members receiving the least amount of individual support--professors and clinical supervisors.

#### Disciplinary Isolation

Participant Two's interview resulted in the development of one main category, disciplinary isolation, supported by the identified codes "value hierarchy" and "ongoing counselor support." Credentials and educational background were described as a means to assigned power on the treatment team creating a system where medical providers led treatment planning within the constructs of their discipline specific philosophy of care,

the medical model. In addition to covert assignment of value, the lack of perceived training preparation and knowledge of the medical philosophy seemed to impact this participant's connectedness to other team members. Participant Two's description of the workplace setting was described by a lack of ongoing support by counseling colleagues and a hierarchy system with a strong emphasis on the medical model framework. With the lack of counselor specific support, and knowledge in the medical language, the participant used the expression "feeling isolated" to describe his general view of the IC experience.

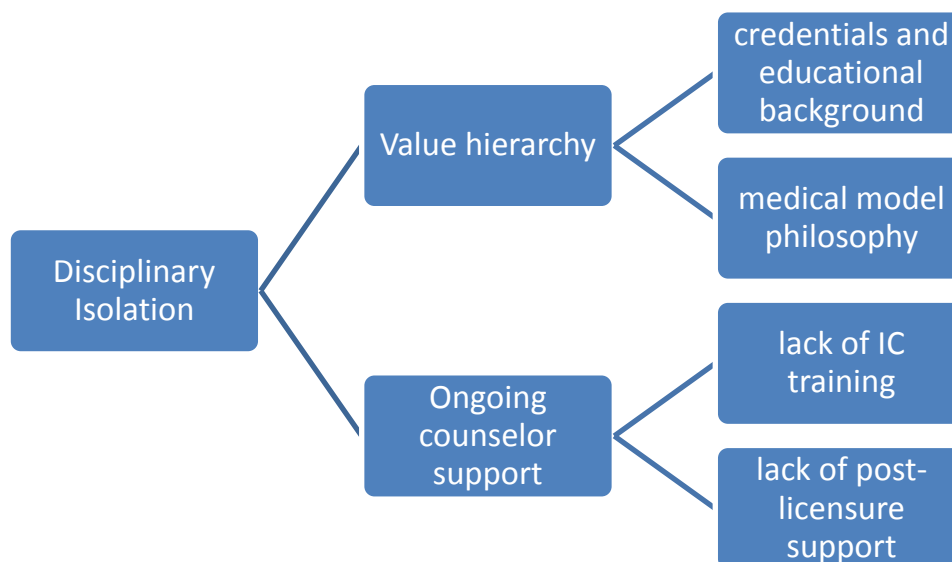


Figure 2: Summary of findings for Participant Two

### Participant Three

Participant Three professionally identified as a psychotherapist at an associate licensure level of practice. Her experience is primarily from her work over the past year at two CABHA agencies with a limited supervisory capacity as a team lead. She described her practice environment as collaborative and one that is divided based on medical and non-medical providers. Client care is provided through collaborative

relationships with behavioral health clinicians such as LPCAs, LMFTs, and psychologists. Medical care follow-up within this collaborative relationship is provided by nurse practitioners, physician assistants, primary care physicians, and psychiatrists.

#### Need for IC Protocols

Participant Three stressed the importance of everyone working together under the same roof for a common goal but with a more intentional focus. She mentioned that having a structured protocol for the practice could help a counselor new to this environment navigate unknown territory.

When I think of different settings for getting experience and having just one internship location, I think that it may be more helpful to have diverse experiences doing internships in different environments; this, I think, would be more helpful.

Participant Three also identified a need for clearer communication of the terms collaborative versus integrated care. Several times in her interview, Participant Three discussed how communication between providers was a consistent issue based on the availability of the medical professionals. While she defined this type of client care as collaborative, she viewed integrated care as more of an ideal and more beneficial. The lack of consistent medical follow-up and team structure was described as having a direct negative impact on client care.

When Participant Three referenced the quality and type of supervision that she received while in her academic program, her emphasis was still focused around the supervision that she received while in the practice environment of an internship in integrated care. When discussing the topic of academic readiness, Participant Three referenced a medical and mental health or behavioral health environment as integrated

care. However, when Participant Three discussed her own current practice environment after her academic training, she used the term collaborative care to describe her environment. Participant Three described her ideal integrated health care setting as one in which phone calls would be more consistent with medical and behavioral health practitioners and medication would be prescribed based on a collaboration of the two.

Participant Three stated:

I feel like the integration that I have had where I have been working has been very minimal and limited, and there's not that integration that I feel like would be beneficial. Like in my mind how it should be working, how close relationships should be.

#### Ethical Considerations

"Ethical considerations," as related to billing and financial security were consistent messages and were identified throughout the interview, such as implications related to Medicaid reimbursement, the impact on time management, and a divide between clinical and administrative needs. Participant Three stressed the need to address and discuss ethical issues --most often with a supervisor. In the IC care setting, Participant Three received her supervision specifically from a behavioral health provider--most often from a different discipline than her own.

Another dimension to "ethical considerations" was identified as a counselor education disconnect. This area of disconnect was expressed by Participant Three when she shared that, at times, there have been decisions made by the agency that challenged her ethical standards that she was taught in her counseling program. One example from the interview with Participant Three centered on the idea of ethical issues came with a

concern about her lack of years of experience to be able to be heard in the way that she would have wanted to be heard. The lack of perceived value from academia for IC settings and the lack of training in the skills vital for working in these settings, highlight disconnect between academia and the clinical practice:

Because I don't want to do something that is not ethical, or I don't want to get into a situation where I feel like I'm having to do something that I don't feel. . .like in those situations where I interviewed there were a lot of holes in the information. . . Red flags would go up when I wasn't getting answers or it seemed they were skirting around the answer.

#### Best Practice Standards for IC Care

The main category identified from Participant Three's interview was identified as best practice standards for IC care and was supported by two codes: "IC protocol needs" and "ethical issues." The lack of leading framework to guide her IC team resulted in a lack of understanding related to the expectation for team roles and responsibilities, ultimately leading to fragmented and lower quality care provided. Focus on financial priorities coupled with the lack of connection to counseling supervisors where described as areas where she questioned the ethical implications. Participant Three's perception of her workplace environment spoke to the bigger systemic issue expressed of the need for an IC structure with best practice standards.

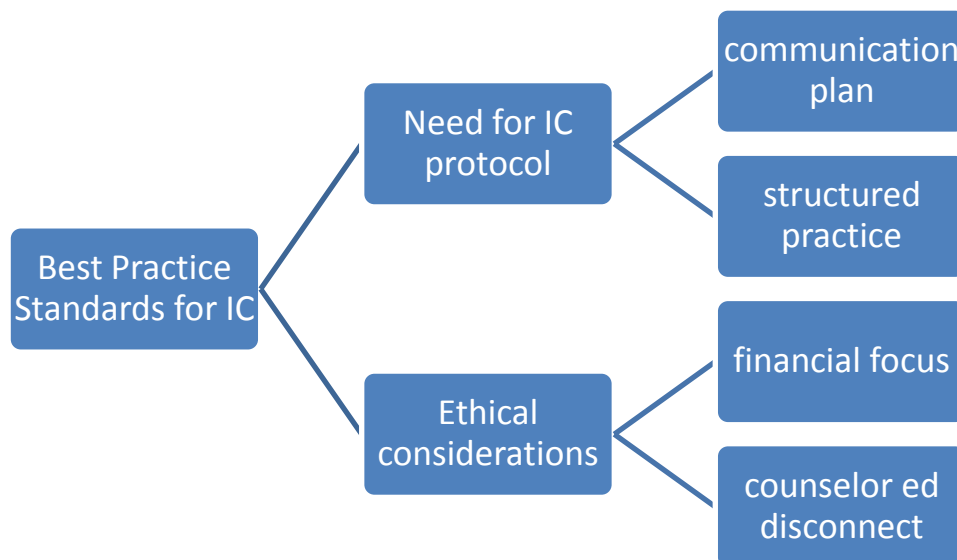


Figure 3: Summary of the findings for Participant Three

#### Participant Four

Participant Four professionally identified as a counselor who is an LPCA and is pursuing an advanced degree. She has worked for over 10 years in different counseling capacities as a school counselor and is currently an outpatient counselor for a CABHA agency. She described her practice environment as a collaborative working environment where several disciplines work on a team together including therapists, gp's, the clinical director, the agency owners, substance abuse counselors, a physician assistant, and a psychiatrist for medical management.

#### Barriers to Supervision

Participant Four discussed the difference between the supervisory needs of the agency versus those needed by the clinician to maintain licensure. Although the agency provides group supervision and an open door policy for support, they do not have an LPCS on staff, which means that Participant Four has to receive her supervision, required

to maintain her licensure as an LPCA, from someone outside the agency. This outside supervision, which needs to be maintained for the entire time that she is employed until she is fully licensed, is not provided by the agency and, therefore, she must pay for it herself. As she described this process, Participant Four's language and tone implied that the agency was well aware that all associate licensed individuals had to receive discipline-specific supervision to maintain their licensure, but they banked on those individuals finding a way to cover the costs without the agency's help.

Participant Four also described an ongoing conflict between the clinical versus the administrative decisions. Participant Four explained how there was always anxiety around reimbursement issues; during treatment team and general supervisor meetings, it was sometimes unclear if decisions were being made in the best interest of the client's needs or for the best financial interest of the agency. Participant Four said:

There is a downside of the supervision piece working in this type of setting. I wonder if others have the same experience working for these agency team settings. There is a climate of business versus clinical, where my supervisor is also an administrator and is pulled between the clinical versus the business decisions. It can be frustrating as a clinician.

#### Membership Roles

Participant Four described her main role as an outpatient therapist--a role that provides less financial reimbursement from Medicaid than that of an in-home therapist. While there are several in-home teams that provide services for the agency, the outpatient team consists of only three therapists. She further described how treatment team

meetings gave priority to in-home cases, often leaving her feeling that she had less of a voice or membership as part of the collaborative team.

I work and do outpatient therapy and, honestly, we are the lowest paid service in terms of reimbursement, and sometimes I can feel that. . . .At times, you can tell there is more energy spent on the services that get reimbursed more. . . .Intensive in-home is the big money thing so when we are in large group meetings I hear management say that intensive in-home is sort-of what supports them. So they really need that to be, you know, where they're getting enough hours and having enough clients coming in and all that kind of stuff.

Participant Four's comments reflected that her perceived value for the agency was dependent on the amount of money she could generate from her role. As such, a value hierarchy was in place that related an individual's potential for reimbursement to the amount of agency attention and support the role received.

#### Financial Implications

The data presented from Participant Four seemed to connect to a larger systemic category related to the financial implications for services provided at her agency. The codes identified as "barriers to supervision" and "membership roles" each related in some way to reimbursement and decisions made based on the potential for the maximum amount of financial gain. Concern for the lack of on-site supervisory support for licensure and questions raised about possible dual relationship between clinical and business operating decisions are based on lack of resources available. Participant Four's perception of her work environment as heavily influenced by financial implications was



described as leading to burnout among her peers and leads her to question if the best clinical decisions are being made for her clients.

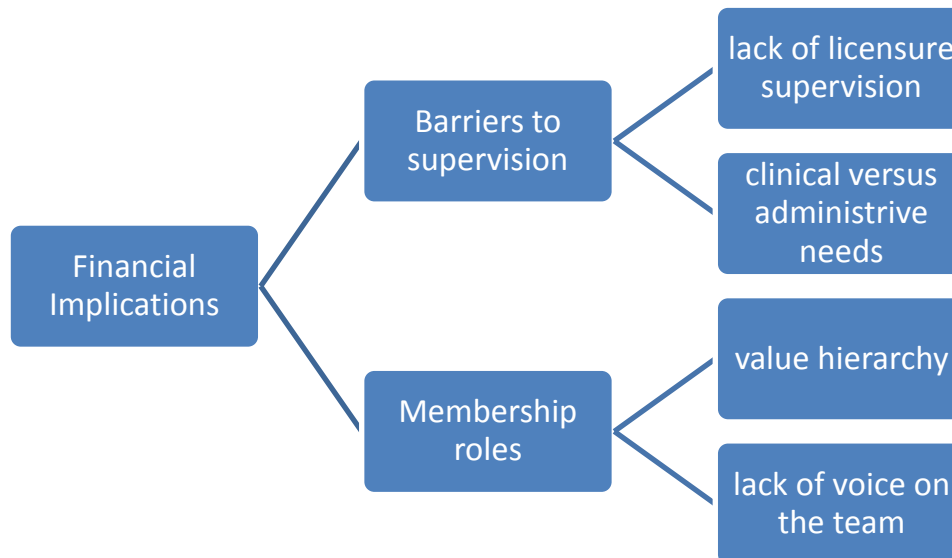


Figure 4: Summary of the findings for Participant Four

#### Participant Five

Participant Five is an LPC in a director position for a CABHA agency. He professionally identified as a licensed professional counselor and provides both clinical and administrative oversight in his current role. His background includes almost 10 years of outpatient therapy and experience in working with disciplines other than those from the counseling field. Participant Five described his current practice environment as a multiservice agency that provides multidisciplinary care by LPCs, EAs, LMFTs, LCSWs, psychiatrists, and a physician assistant.

#### Quality of Care

The first code, "quality of care," included an emphasis on the value of resources. Participant Five described the quality of care provided as dependent on how the different disciplines serve different roles within the agency and how they work together and

separately for client care. Participant Five's description included the presence of different affiliated people coming together for the benefit of a particular client. His support for a multidisciplinary staff focused on what each individual discipline brought skill-wise to benefit the client.

Participant Five focused on the involvement with the community as the collaborative approach most often used by his agency. He presented a more systemic view of how several service areas could come together to provide care and access to services. This participant stressed that if the array of services is not known to service providers, it only hurts the client:

We always reach out to the primary care physicians at least monthly for progress, and we also typically have involvement from DSS or YFS because a lot of our kids are in YFS custody. We also work with the court system when DJJ is involved. So, when I think of multidisciplinary, I think of bringing all those parties together, if they are involved, for the betterment of the client that we serve.

The quality of care provided was also identified in relation to the value for diverse skill sets. Diversity across the training programs would require that each team member bring a unique perspective to the discussion and decision-making process. Participant Five discussed this idea within the framework of being able to provide the best client care. He stressed as critical the importance of staff receiving regular feedback from medical providers and the need for counseling programs to understand the medical part of client care. Participant Five also provided advice for academic curriculum development:

I think it is crucial they know how important it is to get other agencies and other providers involved when need be. If you are just coming out of the counseling

program thinking that you were going to provide your counseling and then call it a day, that is not really how it works. It's going to take you needing to know what the resources are available; it's going to take you needing to know when to refer somebody for different reasons, whether it is psychiatric service whether it is a medical service, whether substance abuse services not only recognizing when referrals need to be made but who to make them to.

#### Access to Care

Participant Five stressed the need to have better access to care and the need for a reduction in the amount of time it takes to get an appointment with a psychiatrist. He also described how a CABHA agency can integrate psychiatry care with psychotherapy plans. Even in cases where the client is being referred from a primary care physician who had been prescribing medication, the structure of the treatment team involved coordination of care with that physician.

Having a psychiatrist here and having our own therapists here makes it a lot easier to work that way [collaboratively] because we have regular staffing with the psychiatrist weekly so they can bring anything to the table then and he can kind of put his two cents in and let us know if we are on the right track or not. So that's a lot easier if you don't have to track someone down. Not only that but we can get people in a lot quicker with a psychiatrist. You know that if an outpatient therapist just makes an outside referral you are probably looking at three months before you can get them in with somebody.

### Benefits of Multidisciplinary Care

The structure of Participant Five's agency improved access to and quality of care for those receiving services and speaks to an emphasis on the value of the multidisciplinary approach. Participant Five expressed positive feedback regarding his work environment and the increased care that results when services are combined under one roof and are joined to collaborate with other community agencies. He also projected a positive framework for a CABHA structured agency. Compared with other participant concerns expressed during the interviews Participant Four responded from a less clinical perspective with a more operational view of the system as whole, a possible reflection of his administrative leadership role.

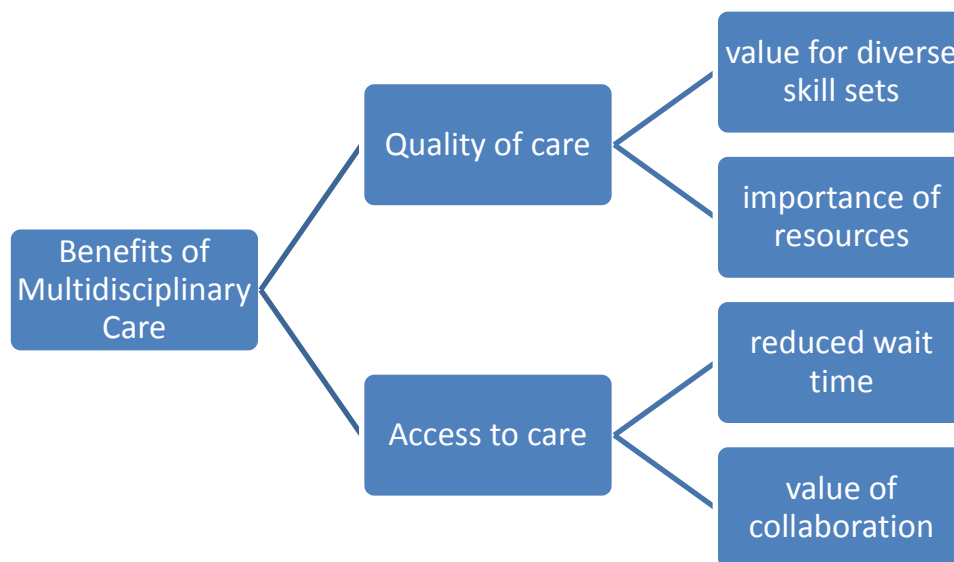


Figure 5: Summary of the findings for Participant Five

### Participant Six

Participant Six is an LPCA working as a team lead at a CABHA agency. She professionally identified as a counselor, comes from a background as an outpatient therapist, and has experience working with disciplines other than those from the

counseling field. Participant Six described her current practice environment as a collaborative agency serving mostly the Medicaid population. Members of her treatment team include LPCs, EAs, LMFTs, LCSWs, psychiatrists, and a physician assistant.

#### Minimum Skill Level Required

The first code, "minimum skill level required" was identified in relation to financial influence and agency structure. For example, Participant Six shared that, as an associate licensed clinician, she could qualify to be a team lead, supervising two other qualified professionals. From her experience, this role had primarily been filled by associate licensed individuals. Participant Six also discussed additional roles such as the substance abuse professionals who can function as a team lead with less rigorous requirements. Based on her explanation of the structure at this CABHA agency, it seemed that the roles were determined by having the minimum required skill level for each position. Participant Six shared her thoughts that most of her colleagues ended up in CABHA agencies because of the abundance of open positions that accept provisionally licensed individuals:

When I was looking for a job, there was an abundance of these intensive in-home agencies that were hiring and because they do accept provisional licensure that's where I wound up.

#### Mock Supervision

Participant Six defined "mock supervision" as a term that centered on this idea that, in a treatment team based environment, the rules may have alternate meanings, especially with supervisory expectations. Participant Six was in the role of a team lead

for a CABHA agency and discussed some of her responsibilities when supervising qualified professionals:

We have a responsibility as team leads to provide supervision to our qualified professionals, which is not necessarily clinical supervision, it is more like an employee supervision relationship. . . ."You're doing a good job this week! Keep it up!" "Make sure notes are in on time." Things like that.

In addition to the lack of supervisory experience, she discussed an additional dimension related to cultural expectations of in-home therapy teams. As team lead, it seems to be her main function to verify that there is proper documentation for Medicaid reimbursement. Participant Six said that she had trouble determining best practices for this situation where she was in the role of supervisor but also being told that this form of supervision could not be considered clinical supervision because of her associate status. There was this questioning of her own readiness to be in a position of supervisory responsibility when she was so new to the field and required frequent and ongoing clinical support.

#### IC Practice Culture

The practice culture of working within an IC environment, as described by Participant Six, was identified as the main category supported by corresponding codes: "minimum skill level required" and "mock supervision." Her reflections of messages that were being conveyed at the agency were described in more covert ways. For example, cost saving measures, such as hiring all provisionally licensed staff with minimum required skills to lead teams, was framed by the agency as an attempt to provide a higher level of clinical care by employing more team members. The term mock supervision,

though used in jest during the interview, carried with it the more systemic view of a practice culture that hires primarily new clinicians, empowers them with this supervisory status as a team lead, and yet limits oversight to paperwork oversight.

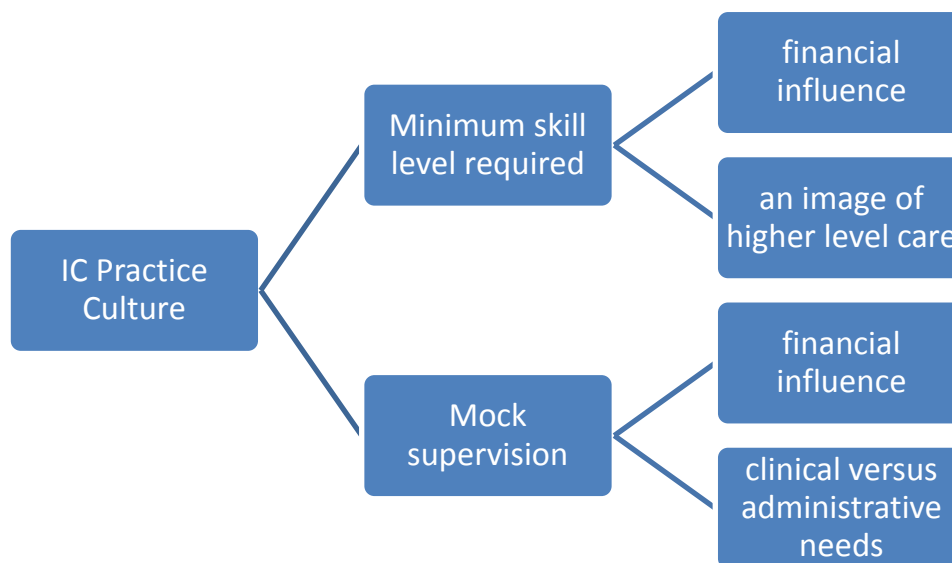


Figure 6: Summary of the findings from Participant Six

### Participant Seven

Participant Seven is an LPC with an advanced degree who also holds multiple certifications and specialties from her academic and clinical training background. She has over fifteen years of experience working in roles as a school counselor, clinical mental health counselor for several community agencies, and as a counselor educator in a university setting.

#### Time is Money

Participant Seven used the expression "time is money" to describe a practice environment where people always felt stressed, overworked, and in a hurry to move to the next thing. Participant Seven mentioned that most clinicians only stay in these care

settings until they are licensed--usually around two years. In addition to seeing high counselor burnout in these IC environments she discussed how recent cuts in reimbursement rates have impacted the operational perspective that everyone needs to do more with less resources.

It was stressful; it was exhausting. I think it's no surprise we have two folks that were LPCAs and dropped out. What is the likelihood that they would stay beyond 2 years, just because I feel like it's exhausting, and it's a lot of liability resting on your shoulders in a system that kind of half-assed things. I know they want to do good, but people don't show up for meetings, decisions have to be made. . . .

She continued to discuss her views related to the current climate of mental health care delivery. Participant Seven used the phrase "broken system" to describe her own feelings about the mental health system that she has been working in for years. When asked about the quality of her work, she responded with candid remarks that carried with them a tone of frustration:

So I would do an assessment and assessments went from what \$150 an hour down to \$86 and that was supposed to spread throughout the agency. So you have to crank more out so, no, I don't feel like it was my best work, but I can certainly take ownership of some of that, but I do feel like I did my best with, you know with consultation, and I did meet with my supervisor, when we were able to meet, but um I'm not going to totally throw the [state] system under the bus, but I don't think that's deniable. I think that it's a broken system.



### Broken System

The concept of "broken system" of care also relates to a lack of adequate support needs due to an effort to save costs by decreasing expenses related to supervision.

Participant Seven would be considered a more seasoned counselor, with an advanced degree and a number of years post-license. Her perspective that people do not stay at CABHA's once they are licensed may also be reinforced by her own personal concern about a lack of consistent supervision, even though she no longer needs the LPCS supervision and has experience in a wide-range of clinical issues. When asked to describe her work in a practice setting where she felt a daily anxiety about financial concerns, Participant Seven said:

A couple weeks would go by, and I wouldn't have any supervision, now I would have consultation with other people... .And I had my license but I definitely felt like again it's an agency setting and it's about "time is money," So, we have to hurry, hurry, hurry. So, to answer your question, I would meet with her it probably averaged out to an hour a week, but three weeks might go by, and I would have had a 15-minute phone conversation with her, you know problem, huge problem.

### System of Convenience

The main category from Participant Seven's interview was identified as a system of convenience supported with the codes: "time is money" and "broken system."

Participant Seven described a relationship between her values and the philosophy of whatever medical provider she might be working with. She suggested that, if she were attempting to collaborate on a case with a pediatrician who was, as she put it, more "old

school," she felt that the atmosphere of the agency reinforced the medical model system where the physician has the last word on the client care. As she communicated her perspective on the work setting and IC in general there was a tone of frustration and regret that she was not able to really provide the type of care she wanted based on the constant demands from the system to do more with less.

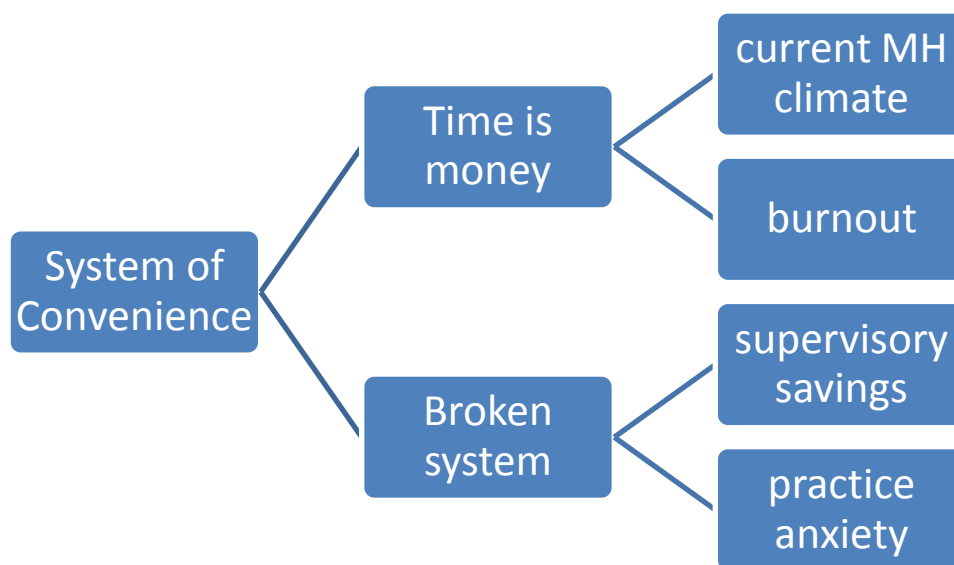


Figure 7: Summary of findings from Participant Seven

#### Participant Eight

Participant Eight is an LPC with a background in counseling with a spiritual care focus. She professionally identified as a counselor and described her work settings as an outpatient practice environment with referral care that is collaborative, as dictated by the Medicaid structure of care. Participant Eight described the members of her collaborative care team as counselors, school counselors, teachers, social workers, psychologists, M.D. specialists, family physicians, and nurses. She said that she rarely works with a psychiatrist in this type of outpatient setting as all her Medicaid referrals and medication follow-up occur through the client's family physician.

### Lack of Structure

Participant Eight described what she termed a lack of structure, in relation to outpatient collaborative practice where the services are not co-located. Participant Eight described this setting as a difficult one in which to receive feedback because communication was never consistent between the professionals attempting to work together while functioning at separate locations. Some of the concerns mentioned were lack of follow-up with faxes and phone calls, difficulty getting to the right care provider in a practice, and the lack of attention paid to cases that had the potential for a higher degree of lethality.

I would say in general professional infrastructure would be great if there's a way that I can do that... doctors, all of them, to do so... if family practitioners you know are concerned about somebody they would call me back, yet I have had some family doctor experiences but nothing is set out, you know this is a system and this is how we do things. . . .

### Co-located Supervision

Participant Eight stressed the importance of having a co-located clinical supervisor to offer more support and structure, especially in higher risk areas where clients have multiple systems involved with their care. Participant Eight used the word "isolation" several times to describe how she felt when she received little to no guidance on more challenging cases.

Yes, and even as an intern I should not have been put out there. . . .Never.

Somebody should have known how the system works or something. . . .That's when I realized it was I was too much to bear. To have been that close to

someone. They should have supported me. I could get upset about that just thinking about right now.

Further evidence for this theme of isolation was identified from Participant Eight's concern about the agency not providing continued supervision for those who no longer require it for licensure. She shared that, for her, this meant that she had to be intentional about asking for support when she needed it.

It is important to keep in good touch with other counselors so that, if you have to think through a case, that you don't feel isolated. You have more opinions about the situation and people that have experience. To me they help you be accountable and more than you get by yourself. There is a counseling group about every three-months, and we bring up cases, but other than that, I decide to call people and say, Hey, can I talk about this case? I have devoted literature but there are certain case where I like to talk to someone.

Participant Eight also mentioned the importance of understanding when to discuss the option for medication and how to navigate the system between family physicians and psychiatrists. She admits that she mainly collaborates with family physicians, as they seem to be more receptive and have multiple staff members, such as nurses or referral coordinators, who are also a member of the client care team. Participant Eight points out that, when working with a psychiatrist, her experiences have been more frustrating because of less timely communication and generally no additional staff who can intervene.

Definitely refer and I would educate them on how maybe they might have this disorder and help attempt to find someone for them. I would tell them it is normal

for a person to feel certain ways, and that you might need medication. And, then, if they feel and I feel a medication might be helpful, I always try to send them to [a] psychiatrist first because they have a medical background. Sometimes people need them because there might be a difference in what they took and the medication needs to be followed.

### Isolation

Isolation was identified as the main category from Participant Eight's interview and supported with two codes: "lack of structure" and "co-located supervision."

Participant Eight referenced the word isolation several times throughout the interview, with increased feelings noted when she described working in high-risk client care areas and at times being the only clinical employee. She described her clinical and structural needs from a developmental perspective based on clinical experience level.

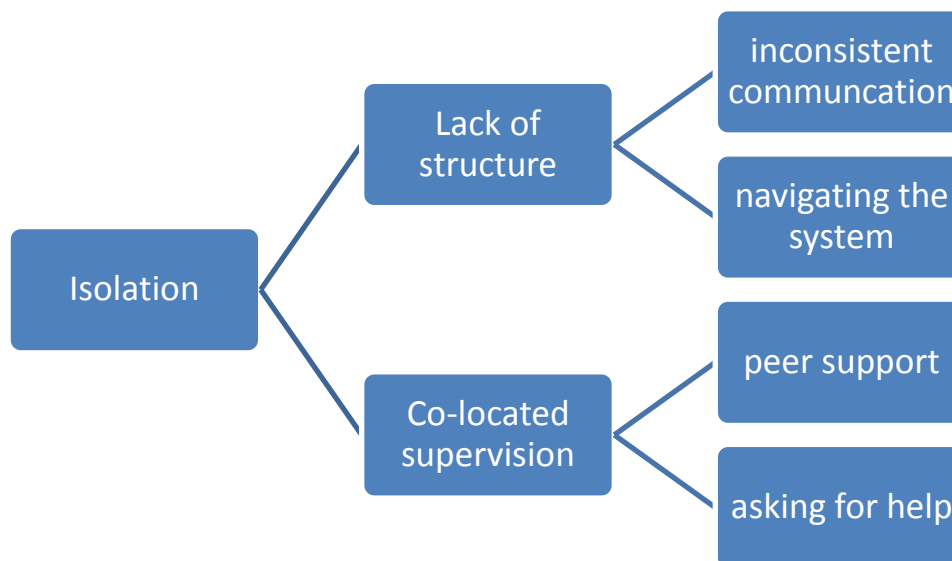


Figure 8: Summary of the findings from Participant Eight

## Participant Nine

Participant Nine is an LPC with an advanced degree in counselor education and a background in school counseling and teaching. She had recently transitioned from working for a CABHA agency where she worked in roles as a counselor, team lead, and administrator. She professionally identified as a psychotherapist and discussed collaboration with disciplines that included counselors, therapists, a clinical director, a psychiatrist, a physician assistant, a substance abuse professional, and qualified professionals.

### Value Hierarchy

Participant Nine described similar viewpoints as other participants in the area of feeling valued within an IC culture. She identified that there was a perceived relationship between the value as a member on the treatment team and education level. Participant Nine discussed how she felt valued and treated with respect because she held an advanced degree:

I felt very much supported. There was another therapist who was exactly the same everything except she hadn't finished her dissertation, and I felt it was just the psychiatrist who knew she wasn't finished, and he treated her so differently than he treated me.

### Mental Health Delivery Changes

Participant Nine also discussed her view on the fallout from mental health changes over the past few years. She described how there seemed to be an overall increase in agency and employee anxiety as well as focus on changing Medicaid requirements. Participant Nine mentioned how difficult it was to just focus on the

clinical work with added administrative emphasis to keep up with Medicaid requirements, and how, for smaller agencies, this could shut down their services for the community:

I am a qualified Medicaid provider but I'm not serving the Medicaid population at all right now just because I just can't keep up with it and it's way too much if you're in private. . . . You don't get that extra support and in the time it takes to learn it, they change the rules and I can't imagine doing that on my own.

This participant had more experience than some of the other LPCAs, and I later reflected that, if that process was so difficult for a more experienced clinician, how would a new counselor feel coming in an environment with increased anxiety and administrative pressures? Participant Nine also commented on the state of mental health services:

I do feel bad for the CABHAs. I feel they are getting a bad ride through this change. Really feel for them, and they're working so hard and all the rules change and people's livelihoods are spinning around. I felt every time I figured out the rules they changed. It's crazy!

#### A New Mental Health Culture

The category identified as a new mental health culture included ideas from the codes "value hierarchy" and "mental health delivery changes." Participant Nine provided a perspective from a clinician who has witnessed change while in varying roles as supervisor, clinician, educator, school counselor, and administrator. Regardless of the roles she held within IC workplace settings, the message of concern for the current state of mental health care delivery was clear. The culture was described as one with

continued focus away from client care, and towards a mode of survival for the agency trying to navigate the constant changes taking place.

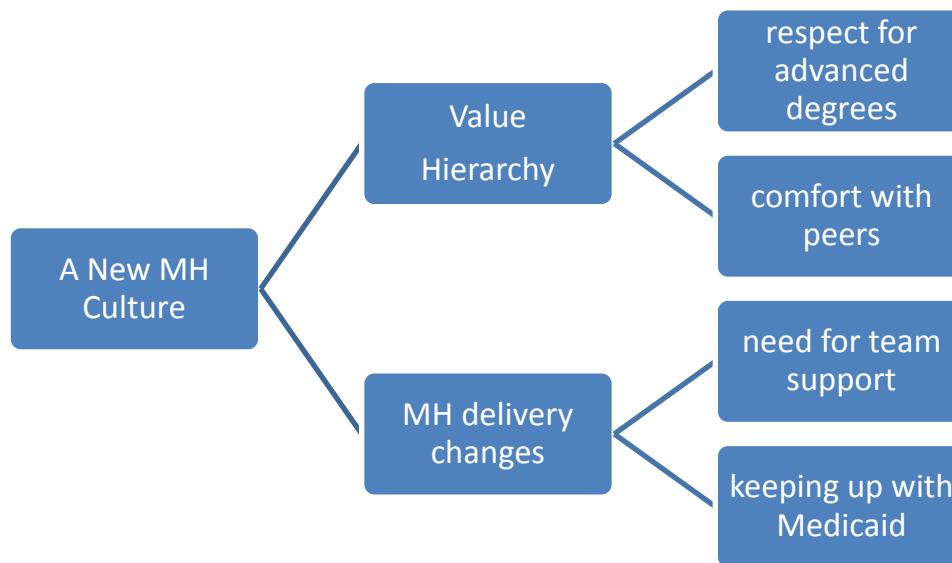


Figure 9: Summary of findings from Participant Nine

#### Participant Ten

Participant Ten is described as an LPC with years of experience in multidisciplinary settings including agency outpatient, college counseling centers, and private practice consultation with a focus on medical collaborative care. She professionally identified as a psychotherapist and described her current practice environment as outpatient counseling in collaboration with a range of medical specialties. Participant Ten's collaborative approach includes working with various healthcare professionals such as OBGYNs, pediatric neurologists, primary care physicians, psychiatrists, counselors, LCSWs and psychologists



### .Navigating the System

Based on the feedback from all of the participants in the study Participant Ten seemed to have the most diverse relationships with medical providers, and much of her feedback included the knowledge she has been able to build ranging from "navigating this system" of not only primary care physicians and psychiatrists, but over a range of specialties. From her perspective counselors will need to understand that working with the medical community will take patience and understanding of a culture that is ever-changing. The following are examples of her perspectives of IC care and hierarchies:

If you want hierarchy of ranking the age-old LPCs are not regarded as highly as LCSWs or clinical psychologists and things like that. I definitely felt like when I was working with people who were medical model focused that there really wasn't anything I could do to change their opinions.

Participant Ten presented a pragmatic view of a system that she feels is biased towards the medical model philosophy. In her view, we have an opportunity to share our insights as counselors with non-traditional medical providers, and, in her experience, this collaboration has worked well for her clients. She added that she had to build the respect with the medical community, over time:

I feel valued as an LPC, and, for the most part, feel [that] others respect my voice, but I had to earn that respect; it was not automatically given to me. In some ways I have to work hard to get other professionals (especially medical ones) to see the patient as more than their diagnosis.

Additional feedback was given around the suggestions for counselor education programs. Participant Ten relayed these suggestions with great emphasis and became

increasingly animated as she shared her ideas. It was evident that working within this collaborative medical environment has taught her valuable insights that she feels could help the field. Participant Ten shared the following suggestions for changes to counselor education programs to help better prepare new counselors for this new era of healthcare delivery:

Having more classes that include case studies such as how would you present to other disciplines, especially psychiatrists. Case studies could also focus on practicing with diagnosis. I think it would be helpful to practice how you would set-up a case and present to a doctor or psychiatrist, having a mock situation. Additional questions could be asked such as "What would you do if you disagreed with the diagnosis?" or "How would you work collaboratively?"

Speaking the Medical Language

Participant Ten also emphasized the importance of "speaking medical provider language" to increase communication:

I think my DSM [Diagnostic and Statistical Manual of Mental Disorders] class in my Master's program was very empowering, not because I could give someone a label or diagnosis, but because I could understand the same thing that the medical world revolves around.

Even though there might be a bias towards the medical philosophy of care, Participant Ten provided examples of how to gain respect from providers as well as improve communication. She made several suggestions for counselor education programs to better prepare counselors for working within these environments. The following selection from Participant Ten's interview stresses the importance of this work

and puts a call out to the counseling field that reminds us that we are also advocates for the clients we serve:

I would just stress the importance for our field to put more focus on how we use psych-pharmaceuticals. I feel this would prove helpful in gaining the respect from medical professionals if we understood side effects, impact from the meds, drug interactions, and overall how the drugs work. I think this would help improve communication when collaborating with physicians. . . .It would help us as a field if we were able to speak the language (in medical care) more fluently. I really think it is important for people to intentionally collaborate because it is the professional and ethical thing to do. I know building that time is hard, especially with the physicians, but counselors should continue to push for collaboration. I feel it should be a "line of vision" as our role within or part of that medical system. I also think it is a part of our role to be an additional voice for our clients.

#### Medical Model Bias

Based on Participant Ten's interview, medical model bias was identified as the main category and was supported with two codes: "navigating the system" and "speaking the medical language." While her feedback centered on the bias towards a medical philosophy, she discussed the importance of understanding the IC culture, such as recognizing hierarchies, learning to build respect, and speaking their language, which are communication skills that can serve to increase collaborative relationships with medical providers. Her perception of her workplace environment was adaptable and her slow tactic to build trust with other disciplines was a unique perspective that seemed to work well for collaborative work, with reports of positive client experiences.

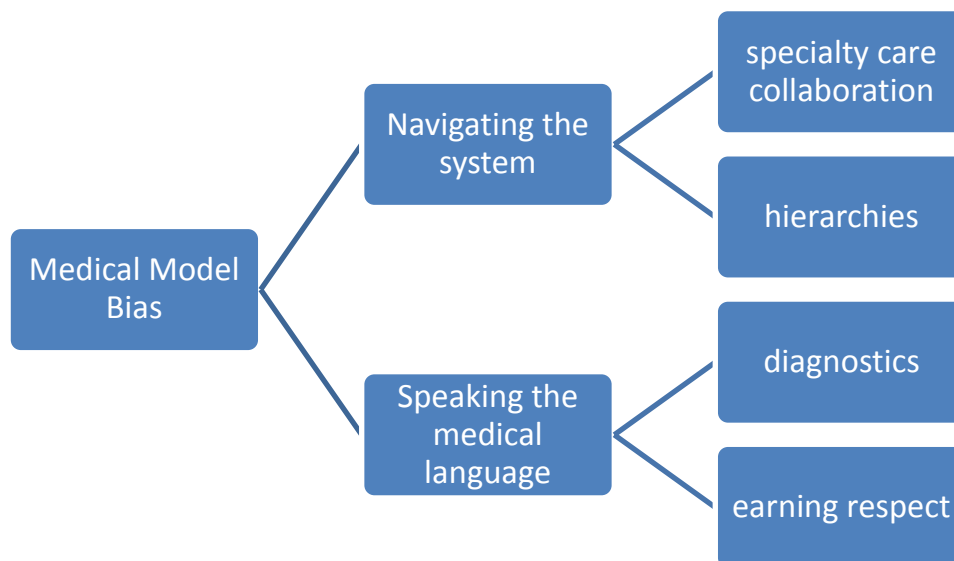


Figure 10: Summary of the findings from Participant Ten

Composite: Etic Perspective

The following section will highlight the common themes that were identified after reviewing all 10 interviews. Examples from participant transcripts will be provided along with a description of each universal category to further highlight similarities for the reader. Based on identified common codes and composite categories, three universal themes emerged: mutual responsibility, disconnect, and isolation. The remainder of the chapter will present details related to the three themes based on the analysis of the 10 interviews. Three visual representations serve as a reference to how the specific composite categories led to a larger encompassing theme. The following matrix outlines these three universal themes:

Table 1: Composite overview Participants One to Ten

Themes	Composite Categories	Codes
Mutual Responsibility	Collaborative approach	Best defines approach to care in their practice setting
		Includes multiple disciplines, similar client goal, having different skill levels
		Used as a clinical term
		Graduate program did not teach skills needed for collaborative work
	Integrated Philosophy	Focus on mutual responsibility- "I can't do this without you."
		Working together for client care
Disconnect	Practice readiness	All mentioned their internship
		Most preparation for working within an IC setting
	Cultural transition	Medical model culture
		Hierarchy
		Integrated philosophy of practice
Isolation	Continued counselor engagement	More experience the less support- peer supervision
		General – non-licensure supervision- staff cases
		Team lead- mock supervisor, there to oversee paperwork for reimbursement
		Treatment team- psychiatrist supervisory role
		Used as the theory in IC care
		Assumed modality during treatment team meetings
		Knowledge of medications
		Medical language
		Membership roles
		Need for academic programs to understand the medical part of IC

## Mutual Responsibility

The initial theme, mutual responsibility, was partially influenced by a collective category identified as "collaborative approach." As mentioned previously in Chapter Two, the counseling field is lagging behind other mental health disciplines when it comes to research in the area of IC care; therefore, most of the terminology comes from the medical community. Whereas the term "interprofessional collaboration" was most often used in the literature to describe a practice setting where multiple disciplines work together, all of the participants in this study preferred to use the simpler term "collaboration" when describing their practice environment.

After analyzing each individual transcript, we identified a pattern for how each of the counselors defined his/her practice setting and had similar perspectives on additional terms for distinguishing these work environments. The universal message across all participants was the use of the term "collaborative care" to describe their approach to the type of care provided. Therefore, while the literature focused on describing a cultural environment, the counselors in this study seemed to be conceptually viewing an approach to care. Participant Two's definition of collaborative care is an example of how this term is used as an approach:

You are able to work together to achieve the same goal which is really good client care, or for clients getting better, or if you want to use technical terms coming up with a treatment plan that is um is appropriate and beneficial to the client.

Participant Six described collaboration in relation to a clinical plan that she and others will participate in while still maintaining their independence:

When I hear collaborative, I think working more perhaps consulting with my colleagues, um I'm already working with the children and the families, but I just think collaborative and family goes together.

The second category that related to the theme of mutual responsibility was "integrated approach." While all participants responded that they would consider their approach to care as collaborative, they also referenced integration as a term that described a common goal. For example Participant Four portrayed integrated care as more "stuck together" than collaborative. Additionally, she described integrated care as a focus on mutual responsibility. Even though all of the participants labeled their current practice environment as collaborative, some discussed the similarities between their concept of the terms collaborative and integrated care. In these cases, this similarity was based on a common goal for integration where everyone is working together to benefit the client involved. Participant Ten shared "I think of collaborative and integrated as in the same ballpark, looking at all approaches and speaking with other professionals to integrate into the best plan for the client." Participant Four described the idea of shared or mutual responsibility:

Integrated sounds more stuck together all the time as opposed to collaborative which would mean coming together [at] certain points; integrated seems more like you're always together meaning "I can't do this without you." Worst collaborative seems like we're just working together to get maybe this one task out; it's one piece.

In the following example, Participant Four defined collaborative care in relation to integrated care:

I would say that we are more collaborative here at our agency than integrated because there are some pieces that really work independently of others so I would say that we are more collaborative than integrative.

Based on the previous examples, there seems to be similarities in the references to what they view as a more autonomous practice approach with collaborative care and a more dependent practice culture when they reference integrated care.

While the term interprofessional was not familiar to the participants in this study, some provided a guess as to what they felt the term would mean. In some cases, the participants had never heard the term interprofessional used before but had an idea of what it meant. Participant Eight described her thoughts as follows: "I do think that, with interprofessional, it was more than a doctor's in charge or somebody who's got a handle on this...with integrated sort of the same but a little more give-and-take in some way I'm not sure." Others, such as Participant Ten, related the term to the level of care provided "I think of the term interprofessional as the broadest of the terms, looking at higher level of care." The following example, from Participant Nine, felt that using the term professional could be confusing in that the reality is that many of the professionals they reference have such a broad range of educational backgrounds:

Interprofessional really I'm not familiar with that term so my impression would be among or between professionals and interestingly what just popped into my brain is "What qualifies them to be interprofessional?" because, you know, in those settings you have the Bachelor's level person with maybe two years experience we also have a psychiatrist so there's really of broad range of educational levels and experience levels.



While collaboration may be viewed in terms of an approach to the care provided and integration a way to describe the interactions between the allied health professionals, each of the participants appeared to rely on the concept of mutual responsibility to carry out the care to their clients. Although none of the participants were familiar with the term interprofessional, they still understood similarities to an integrated philosophy as they referenced a higher level of care with more interdependence on one another. From this larger etic view, the participants noted that each person involved in the delivery of care, from health to behavioral health, has a part to play. This theme also crosses over all practice settings. Therefore, whether the providers are under the same roof or at separate locations, there is a sense that, by working together, regardless of the practice environment, other providers will also be a part of the care provided.

On the other hand, collaborative care could be seen as a component of an approach to care that will be provided by individual disciplines within a team. An integrated philosophy could be seen as the component that describes the practice culture of the interprofessional communication and interaction with one another. Also, the word interdisciplinary was used across participant interviews while interprofessional was unfamiliar to them. If counselors conceptualize IC care as an approach, then the disciplines are coming together to collaborate. On the other hand, if they were to view a culture of care that includes professional interdependence, mutual responsibility could be viewed as the larger context of influence. The following figure illustrates two independent concepts, collaborative approach and integrated philosophy, that, viewed together, could create a cultural context for mutual responsibility to exist.

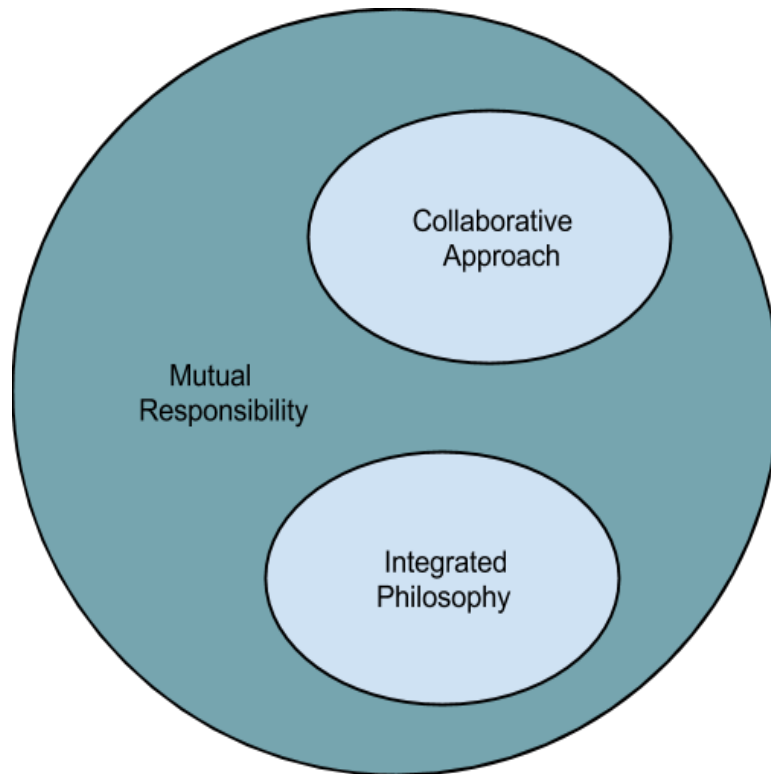


Figure 11: Theme one mutual responsibility

#### Disconnect

The second theme of disconnect included a composite category related to readiness to work within an IC practice setting. Based on the participant's response to the question of what they felt most prepared them to work in an IC setting, all 10 participants included their internship experience. While the participants had been placed in different practice settings for their internships, including hospitals, agencies, schools, and clinics, most were placed in environments with treatment teams. Participant Four found her internship experience to be the most helpful to prepare her for being in an integrated or collaborative care setting. Some participants mentioned the internship as something that prepared them for a practice environment that would have a medical model culture, separate from what they were learning within their counseling program of

study. Others, such as Participant Five, credited their internship experience as being helpful for understanding the cultural transition.

One of the limitations of their IC internship was the need to make sure that there was structure and support from the placement site as well as from the academic program. It was suggested that it would be helpful, and perhaps should be a requirement, for the academic supervisor to make a site visit to have a better understanding of a more integrated philosophy of practice. Participant Eight also commented on the importance of cultivating a working relationship to better bridge the medical and behavioral health divide:

When it came to internships, we had no good solid plan about doing supervision during internship, and I raised a lot of concerns at that time because they would send me to places that were not well...I mean they should have had more classes. I should've had more help had exposure to medical and behavioral health collaborations.

Participant Ten also stressed the importance of the internship site being involved and communicating with the academic program:

My internship experience did not use a collaborative approach or encourage one. So, mainly, during my intro courses and some from my professors during the internship class. Even though collaborative care was weaved throughout these intro classes, it was still not a focus.

Participant Nine described her feelings about the importance of multi-cultural competence:

I didn't have a very diverse practicum experience or internship. My internship essentially involved a small town outside [the city]. My clientele looked a lot like me, and so, when I jumped into the other [IC care] and there was a big difference. Not that I want the school to work at it, but at the same time if there was some way to provide more diverse practicum experience the classes would be valuable

The second composite category that influenced this theme of disconnect was identified as cultural transition. Mentioned across the participant interviews was a view of an unfamiliar medical model culture where one felt ill-prepared for the demands of the practice. Participant One, in contrast to the others, had a positive training experience that helped prepare him for respecting all levels of roles on the team. He also learned a style of communicating that helped him accomplish a more collective goal for the clients being served. The shift was away from ownership for the care of the client to a team responsibility that focused on providing holistic care.

Another component of the culture that was discussed was the area of hierarchies of team members. Many participants mentioned feeling that the medical physician was the ultimate one in charge and, therefore, that the hierarchy of the membership roles was based on education and experience level. Participant Two shared that, even though he held an advanced degree, the structure of the Medicaid reimbursement system only allows M.D.s or Ph.Ds. or Psy.Ds. (psychologists) to sign the forms for the CABHA agencies. This is an example of a larger political/economic influence that increases the breadth of the mental health system.

Another cultural transition seemed to relate to the shift to a business model structure in the agency setting. Participants had similar feedback about the balance

between administrative and clinical needs. Participant Three shared concerns that she had expressed to her agency in the past about being in a team lead position as an LPCA, because she struggled ethically with not feeling that she should be supervising others because of her limited level of experience. The theme across the interviews seemed to be that, with the reduction in funds, everyone was expected to do more with less, and, for some, like Participant Seven, this new culture of mental health delivery was burning people out and resulting in a reduced quality of care.

A final component to the category of cultural transition was based on the integrated philosophy of practice. As mentioned earlier, many of the counselors described their practice setting as an approach to care. Void of a cultural dimension, the counselors did not describe any particular theoretical lens. Although the medical model is what is referred to as the BPS model in the literature, none of the participants used that term when describing their practice setting. The lack of any mention of a medical model, beyond general terms, gave an impression across interviews of a level of discomfort of operating within the medical model framework.

The theme of disconnect was presented from the combination of composite categories in the areas of practice readiness and cultural transition. As with the previous theme related to mutual responsibility, the findings suggest that there needs to be a connection between academic training and the IC culture in order to foster the engagement of new counselors entering these settings. Based on the findings from this study, disconnect while working in practice could be a result of a lack of connection between educational training and readiness for an IC practice culture.

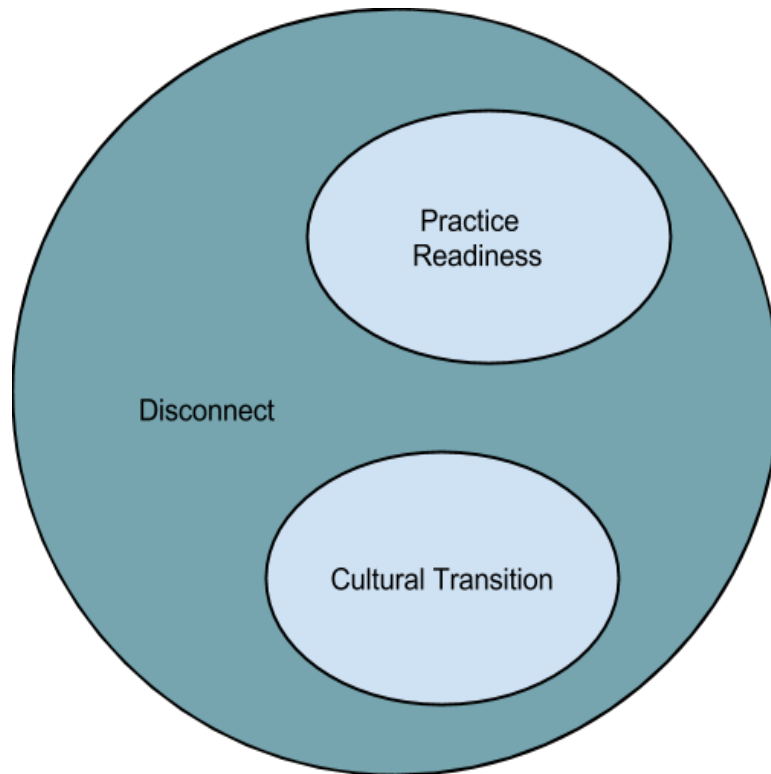


Figure 12: Theme two disconnect

### Isolation

The third theme, isolation, was an overriding term that described how a counselor continues to stay engaged in the field as related to IC care. There was a common thread to all the interviews: the more education and experience someone had the less support or supervision they received, with none of the licensed professionals receiving structured supervision although a couple attended peer supervision groups. Participant Ten described how she continued to receive support post-licensure:

I attend a monthly group with other LPCs and LPCSs to staff cases and have 2-3 colleagues who I am able to call if needed. I had a past case where a client killed another person. I really needed support during that time and was able to receive support through peer supervision.

While supervision was typically carried out by someone other than an LPCS, there was also an academic component of supervision that occurred while some of the participants were in their counseling program (primarily doctoral level). Although some participants suggested disconnect between academic learning and the reality of the work environment, others mentioned that the peer supervision piece was helpful because it helped them to hear from others within collaborative settings. Participant Seven discussed her experience with a non-LPCS supervisor:

I had an LMFT who was my supervisor who didn't understand the LPC requirements and there was um so the LMFT was my supervisor and it was funny the things that I remember getting my evaluation from her and the things that um, she would give me lower marks on, and again we're talking like it was above average instead of superior. It wasn't anything bad, but it was things like family systems um, and we just came from different approaches. I mean now I see that it's important and that it would be very valuable to have that information but that wasn't my discipline.

Supervision was also discussed as a teaching or learning tool. According to Participant Five, a general supervisory role does not provide specific licensure supervision. When asked how he continued to receive supervision or support, he stated that there were no specific peer supervision groups that were established although he mentioned that it would probably be helpful in the future. Participant Five continued to describe more specifics on the structure that was involved with supervision and the link to individual counselor goals.

Supervision from non-counseling supervisors and the medical practice culture seemed to contribute to another area of "multidisciplinary boundaries." While supervision was identified as having multiple levels of support, the reliance on M.D. and medical social workers to supervise counselors also seemed to perpetuate this theme of isolation. Participants described differences in the medical model philosophy as compared to a more developmental model that most counselor education programs teach. Learning to communicate with medical providers seemed to be a skill needed to help improve communication and client care. Participant Ten described what she felt was needed to improve communication with medical providers:

I have found it really helpful to understand the full picture of the client to have knowledge when speaking with their physicians. I feel most counselors are not prepared coming out of grad school with a level of understanding that that is needed to work collaboratively with other disciplines, especially physicians.



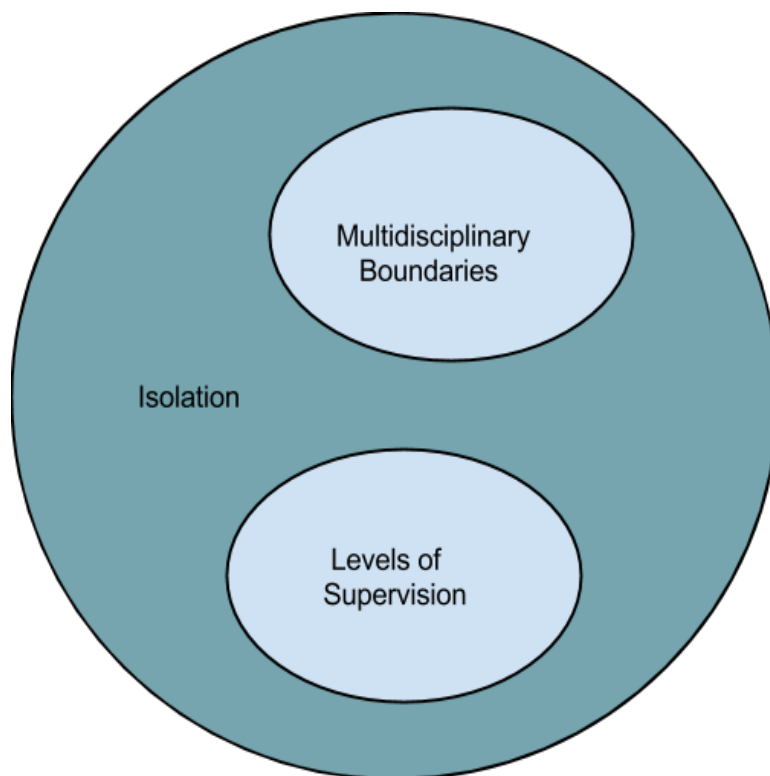


Figure 13: Theme three isolation

### Summary

Chapter Four included descriptions and interpretations of 10 interviews with counselors who are currently working within interprofessional collaborative care settings. The chapter included emic perspectives from each participant on their lived experiences within these settings. A graphic display was presented with pertinent perceptions from the 10 counselors who provided their feedback. The chapter also included a composite description from an etic perspective across all participant experiences.

## CHAPTER 5: DISCUSSION

### Introduction

The purpose of this study was to understand better the perspectives of counselors who practice in interprofessional collaborative care settings as related to their academic readiness and their level of workplace supervisory support. Ten participants were interviewed who were either licensed or associate licensed counselors, had completed their academic training from a CACREP program, and who met the criteria of working within an interprofessional collaborative care setting. Participants were all asked questions based on their perspectives on their lived experiences within these multidisciplinary workplace settings and their thoughts and feelings about their academic preparedness and ongoing supervisory support.

The questions that framed this research were: (1) What workplace factors influence counselors who practice in interprofessional work settings? (2) How does academic training readiness impact counselors working in IC settings? and (3) What are the supervisory needs of counselors working in IC environments? Chapter Five will present a summary of the major findings and how they answer the research questions. Discussion points will include the composite themes presented in Chapter Four and will be followed by limitations of the research. A conclusion will present implications for counselor educators and supervisors, as well as for practicing counselors in IC settings and future research.

## Workplace Factors

The initial research question sought to understand what workplace factors influenced counselors who were employed in IC settings. The findings suggest that workplace factors could be better understood through the composite theme of mutual responsibility. Participants described factors related to an approach to care, the communication between the disciplines, and the impact from a changing mental health system. These factors set the stage for their degree of interdependence in the workplace and ultimately influenced the culture of interprofessional settings from the perspective of counselors.

### Approach to care

The findings in this area suggest that counselors view IC as an approach where disciplines collaborate for improved continuity of care for their clients. Findings also suggest that counselors perceive their practice setting to be collaborative, not integrated or interprofessional, which contrasts with the terminology commonly found within the literature. Although collaborative care could be carried out at the same location or between locations, the participants used the term collaborative to describe their view regarding what they do and the type of care that they help to provide. Even though they described their setting as collaborative, many participants expressed a need to move to a more integrated philosophical approach where there was a culture of interdependence in the workplace.

### Communication

Participants expressed the need to open up the communication between disciplines in order to understand better everyone's role and better serve the client using unique disciplinary strengths. They concluded that a collaborative approach alone does

not paint the entire picture of the workplace setting; the relationships between the disciplines is a factor that also influences the IC culture. Findings suggest that, while an approach to care may be collaborative, integration would demand a greater sense of interdependence on one another. This interdependence would mean that there was a culture of mutual responsibility a composite theme, where disciplines would come to the table trusting and relying on each other to provide the best treatment for the clients that they serve.

Some of the distinctions made by the participants between collaborative and integrated care are supported in work by Doherty et al. (1996) and Blount (2003) who described this care as coordinated, co-located, or integrated. Coordinated care, as described by Blount is the most similar to participant descriptions of care provided from separate locations. The term co-located (where providers would share the same physical location but provide a separate treatment plan) did not fit any participant descriptions of practice setting (Blount). What Blount considers to be integrated-- same location and a shared treatment plan--most closely mirrors what the participants of this study framed as collaborative care. The difference in these terms could impact best practice recommendations if disciplines are not speaking the same language about the type or approach to care that they are providing.

#### Impact from MH changes

There is evidence that healthcare is moving to a framework of interprofessionalism, not interdisciplinary care, based on the inclusion of this term within the 2011 IC competencies (IECEP). D'Amour and Oandasan (2005) described this shift to a more holistic focus towards interprofessional education and practice. If we are moving towards an interprofessionalism view of care across disciplines, counselors will

need to learn to be confident in their unique skills set while learning to trust, respect, and work collectively with other disciplines. This structure would also take into consideration a practice environment that values a new business model that some of the participants described when discussing this balance between providing care and affording care. Studies such as Miller et al. (2011) lend further support to findings that participants are faced with a high-pressure business model to provide combined mental and medical care.

Participants also described differences in the practice setting as related to factors of mental health reform and economic constraints. For instance, counselors were collaborating with each other for the provision of care for Medicaid eligible clients and were also operating from an independent discipline focus plan. Some of these members were co-located and others were in separate locations sharing client caseloads. Some included family physicians and others psychiatrists, but all included at least one medical provider of care.

Much of the research referenced in Chapter 2 included frameworks that pertained to primary care settings where teams used a collaborative approach and integration relied on a culture of responsibility that was interdependent on one another. Prior to recruitment of participants, the researcher understood that primary care settings were not currently populated with counselors in the geographic area where the research was being conducted. While some primary care placement sites include a behavioral health component, these roles are mainly filled by nurses or social workers.

#### Academic Readiness

The second research question asked how academic readiness impacted counselors within IC settings. The findings suggest that one of the universal themes of

disconnection impacts academic readiness in areas of training in interdisciplinary care and in understanding of the medical model culture. An understanding of these areas could help to inform best practices for counselor educators.

#### Interdisciplinary training

The composite theme, disconnect, seemed consistent with findings from the literature that point to communication barriers across the mental health and medical health disciplines, emphasizing the need for a collaborative structure that would assume competency in the area of interdisciplinary care (Harkness et al., 2003 and Thomasgard et al., 2004). Throughout the interviews, some specific suggestions were provided that participants felt would be helpful to better prepare new counselors for IC settings including training in crisis counseling, knowledge of psycho pharmaceuticals, medical model collaboration, family systems, and assessment and diagnosis.

Participants also endorsed the value of their internship experience as the most beneficial to prepare for a transition to a multidisciplinary practice setting. Findings suggest that the internship experience is a way to bridge the academic with the experiential disconnects. While most participants had experience interning in a multidisciplinary setting, findings showed that academic coursework did not prepare them for a collaborative care environment. Additionally, all participants mentioned the lack of training and readiness to work with disciplines other than their own.

#### Medical model

Participants also expressed the need for added exposure to the medical model, while in their counseling program, to better prepare them for the collaborative treatment team workplace. Findings from this study support the literature that the medical model is the leading framework used within IC care settings (Frankel & Quill, 2005). Although

support for use of the medical model was found, references to common terms from the allied health literature such as the BPS model, patient centered care, or medical home were not mentioned during any of the participant interviews. The literature in IC uses a medical terminology and frame of reference, while the counselors were less connected to this paradigm and practice culture.

Some common components to this model included knowledge of medications, diagnostic indicators, and a hierarchy with a lead physician to oversee the care provided. Although treatment team members included diverse multidisciplinary backgrounds, the only theoretical model referenced within a team approach was that of the medical model. Based on the findings across interviews, it was assumed that counselor education programs should provide practice model knowledge within this BPS modality and provide an understanding of medical terminology related to this care. The inclusion of academic training in the medical model could help counselors have a stronger voice on a treatment team that will most likely continue to follow that paradigm.

### Supervisory Needs

The third research question asked about the supervisory needs of counselors working within IC settings. The findings suggest that the composite theme of isolation most closely impacted counselor engagement as related to support through supervision. Supervisory needs included having non-counselor supervisors and a lack of multi-disciplinary supervision frameworks. The information shared by the participants help to provide a better understanding of the supervisory needs of counselors along the continuum of their career from student to licensed professional.

Non-counselor supervisors

As previously mentioned, supervision in these multi-disciplinary settings was primarily carried out by a non-counselor supervisor. The lack of similar disciplinary backgrounds forced most participants to receive supervision for licensure outside their workplace for which they were required to provide compensation. In such a situation, the counselor engagement level becomes low, and there is a strong feeling of isolation--a composite theme-- that might be higher because of the lack of consistent supervisory support. Additionally, it would be important to consider ethical concerns and knowledge of levels of supervisory need from student to professionally licensed counselor.

One unexpected area of concern was the lack of supportive options for counselors who are post-licensure. The findings indicated that, the more education a participant had and the responsibility he/she was given, the less support he/she received. In these cases, developmental support for counselors stopped when they reached licensure status. If support was needed, the licensed counselor had to seek a peer support group on his/her own.

#### IC supervision frameworks

A composite theme of isolation was identified as related to this area of supervision and ongoing support in these IC working environments. The findings support the need for formal structures for supervision in IC care settings (Davies et al., 2004); (Hernandez, 2008) and the concern for isolation expressed by Reid et al. (1999). Although the BPS model is the leading model in practice, findings support that no formal education is provided in counselor education programs. The medical model will continue to set the standard of practice for interprofessional care as interprofessional competencies influence medical school curriculums. It will be crucial for supervisors to understand this



model and be able to help supervisees adapt to a workplace with allied health professionals who practice within its theoretical framework.

### Limitations

#### Participants

The study purposively selected participants based on similar academic backgrounds, disciplinary similarities, and IC workplace environments; therefore, transferability and generalizability is limited. While there was some diversity across participants, mainly within the area of experience and type of role within their team, it was hoped that the participants would have represented a more diverse sample of gender and race.

#### Telephone interviews

The researcher attempted to conduct all interviews in person and was able to do so with seven out of the ten participants. For three of the participants, time and distance constraints made it a hardship for them to participate in person. In those cases, the interviews were recorded via speakerphone for transcription purposes.

#### Researcher subjectivity

As stated in Chapter Three in the researcher subjectivity statement, my own experience and background could also be considered a limitation to the study. My perceptions of the changing climate in mental health delivery and attitudes about disciplinary conflicts were similar to those expressed by the participants in this study. Although I did not express my own views on IC care, some of the participants had knowledge of my background and referenced terms that they knew I would understand without formality. My own background could have contributed to the rapport building, and should also be considered a limitation of the study.

## Implications

As presented in the literature review, mental healthcare delivery is shifting to a more integrated medical and behavioral health philosophy to help reduce overall costs, increase client satisfaction, and improve quality of care (Margalit et al., 2004; Roberts et al., 2009). While many allied health professionals have conducted research in the area of IC care, there is a dearth of research from the counseling field. Nelson et al. (2000), Myers et al. (2002), and Lopez-Baez and Paylo (2009) stress the need to provide adequate training and support for counseling professionals who will be providing collaborative care.

With few studies even addressing IC care in relation to counselors, the rationale for this research was to understand the needs of counselors currently functioning within this environment and explore factors that impact their practice culture. Based on the findings from this study, I would recommend an emphasis on designing counselor competencies that integrate components of the biopsychosocial theory and train counseling students in collaborative care skills, such as case presentations, medical terminology, and working as part of a treatment team. I believe that, in addition to these competency areas, supervisory frameworks should be put into place that take into consideration the practice culture of IC care for those who will be placed in supervisory positions.

In addition, I would recommend finding opportunities to collaborate with other disciplines in the allied health fields to understand better how all the roles can fit together. One suggestion would be to cross-train at the university levels. For instance, if a school had programs in counselor education, social work, psychology, nursing, and a medical school, leaders from each of those programs could design curriculums for a

collaborative training that would showcase the unique skills each profession brings to the practice setting and to improve healthcare for the clients served.

The interpretations and findings from this research study could be applied to counselor educators and counselor supervisors, as well as disciplines outside of the counseling field and those who will supervise counselors at the internship or licensure levels. This study could also be adapted for future research in IC care with other IC teams and other mental health disciplines. Implications for each of these groups will be discussed in the following section.

#### Implications for practicing counselors

The participants in this study did not identify one unified term to describe their identity (for example, counselor). While all completed clinical mental health programs (identified as meeting CACREP standards) some had previous training in school counseling, psychology, or marriage and family therapy. Malin and Morrow (2007) used the term trans-disciplinary to identify counselors within interdisciplinary settings. Their study suggested that counselors who enter these integrated practice settings will need to establish their own identity that fits with their professional roots and allows them to work together with others outside their field of study.

#### Implications for counselor educators and supervisors

Based on the findings from this study, it seems reasonable to conclude that there is a disparity between training and practice in IC care, similar to previous IC studies such as Hays et al. (2002). Competencies that bridge interprofessional education with collaborative practice, such as the IECEP (2011), could provide a good foundation to help counselor education programs design internship programs, devise supervisory frameworks, and offer coursework to help prepare counselors for these IC settings.

Based on the recommendations from the participants in this study, there seemed to be a pressing need to establish best practices for counselor educators and supervisors who will be responsible for training and preparing future counselors, and those who will support them, to work within these practice settings. The current CACREP and ACES standards do not include provisions for collaborative treatment team settings where multiple disciplinary structures work together. In order to ensure that counselors are part of these settings and have the confidence to have a voice on the team, we need to provide structure, guidelines, optional academic electives, and an understanding of the medical culture. As the 2016 draft of the CACREP standards continues to be updated, it is hoped that some of the recommendations from this study be taken into consideration to include best practice recommendations for IC settings.

For counselors to receive the required level of supervision within their workplace environment there will need to be an LPCS on staff prepared to offer multidisciplinary supervision. Counselor education and supervision programs could also encourage individuals to create their own theory of supervision to encompass the skills necessary for a multidisciplinary supervisor. Offering alternative structures to a one-dimensional philosophy could help to increase a counselor's comfort level to work in IC settings.

It also seems crucial to support counselors at all levels, especially as they become more removed from academic or associate levels of development. There were some participants who were licensed but who did not have their LPCS which is necessary to supervise co-workers with associate levels licenses. None of these participants saw an added benefit to completing this requirement. As counselors gain additional experience, their feedback would be valuable and maintaining supervisory status could keep them engaged with other counselors who are at their peer level.

### Implications for future research

As discussed in the literature review there is a substantial lack of research in the area of clinical care, with much of the counselor research over the past decade falling under areas that would not include supervision or clinical practice. Part of this clinical care included internship feedback and needs. As the findings from this study point to the importance that counselors placed on how their internship experience prepared them for these IC settings, it would seem reasonable that as a field we would need to be studying these learning sites to better understand counselor needs for support.

It would seem advantageous to counselor educators to research and develop supervision models that are multidisciplinary in focus. Supervision models such as the MPM (Davies et al., 2004) could also be studied and used in future research in the area of supervision for counselors in IC practice environments. Measurable inventories such as those used in Davies et al. (2004) could help provide further ongoing support and clarity needed for supervisory competency areas in IC care.

The results from this study also provide support for research that would remove the communication barriers among allied health disciplines. This sentiment was echoed from Thomasgard et al. (2004) as they suggested the need for multi-professionals to have a collective structure. If we are in fact moving to an era of interprofessionality as an emerging field, as suggested by D'Amour and Oandasan (2005), support for this interdependent relationship between the providers will need to be understood through collaborative research designs. Many of our counseling education programs are housed within academic settings where other provider disciplines are also taught. Perhaps collaborating for increased knowledge across disciplinary lines would help to support

everyone's role and provide for a better transition to practice settings that will demand IC care.

### Summary

Three research questions helped to guide this inquiry to better understand the needs of counselors who work within IC settings. Findings related to workplace factors, academic readiness, and supervisory needs were discussed. Composite themes of mutual responsibility, disconnection, and isolation helped to provide a better understanding of practice implications and possible next steps for the continued support of counselors in these multi-disciplinary settings.

## REFERENCES

- Aitken, J. B. & Curtis, R. (2004). Integrated healthcare: Improving client care while providing opportunities for mental health counselors. *Journal of Mental Health Counseling, 26*(4), 321-331.
- Agnello, M. F. (2001). An Illuminative Account of Personal Professional Conflict: Redefinition and Reemergence of Self in the Process of Ethnographic Research; Chapter 7, *Community Based Ethnography*. Psychology Press: New York, NY
- Appelbaum, S. H., & Gandell, J. (2003). A cross-method analysis of the impact of culture and communication upon a health care merger: Prescriptions for human resource management. *Journal of Management Development, 22*(5), 370-490.
- Arthur, N. & Russell-Mayhew, S. (2010). Preparing counselors for interprofessional collaboration through supervision and lateral mentoring. *Canadian Journal of Counseling, 44*(3), 258-271.
- Association for Counselor Education and Supervision Task Force Report (2011). Best Practices in Clinical Supervision. Retrieved from [acesonline.net/wp-content/uploads/2011/10/ACES-Best-Practices-in-clinical-supervision-document-FINAL.pdf](http://acesonline.net/wp-content/uploads/2011/10/ACES-Best-Practices-in-clinical-supervision-document-FINAL.pdf)
- Baird, B. N. (2008) *The Internship, Practicum, and Field Placement Handbook, Fifth Edition*. New Jersey: Pearson.
- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, and Health, 21*, 121-133.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Harvard University Press.
- Council for Accreditation of Counseling and Related Educational Programs (2001). CACREP 2001 Standards. Retrieved from [67.199.126.156/doc/2001%20Standards.pdf](http://67.199.126.156/doc/2001%20Standards.pdf)
- Council for Accreditation of Counseling and Related Educational Programs (2009). CACREP 2009 Standards. Retrieved from [67.199.126.156/template/page.cfm?id=5](http://67.199.126.156/template/page.cfm?id=5)
- Council for Accreditation of Counseling and Related Educational Programs (2009). CACREP Policy Document, revised, 2012. Retrieved from [cacrep.org/doc/2009%20POLICY%20DOC%20rev.%20Feb%202012](http://cacrep.org/doc/2009%20POLICY%20DOC%20rev.%20Feb%202012)
- D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care, 19*, 8-20.

Davies, E., Tennant, A., Ferguson, E., & Jones, L. (2004). Developing models and framework for multi-professional clinical supervision. *British Journal of Forensic Practice*, 6(3), 36-42.

Degeneffe, C. (2006). Review of 'clinical supervision in the helping professions: A practice guide. *Rehabilitation Counseling Bulletin*, 50(1), 59-60.

Doherty, W. J., McDaniels, S. H., & Baird, M. A. (1996). Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*, 5(5), 25-28.

Edwards, T. M., & Patterson, J. E. (2006). Supervising family therapy trainees in primary care medical settings: Context matters. *Journal of Marital and Family Therapy*, 32(1), 33-43.

Employee Retirement Income Security Act of 1974 (29 U.S.C., 1185a). Amendment: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129-136.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137(5), 535-544.

Enochs, W. K., Young, M., Choate, R. O. (2006). Counselors and physicians providing mental health services: An integrated approach. *Adulthood: Theory, Research and Practice*, 5(2), 101-113.

Frankel, R. M. & Quill, T. (2005). Integrating biopsychosocial and relationship-centered care into mainstream medical practice: A challenge that continues to produce positive results. *Families, Systems, & Health*, 23(4), 413-421.

Gibson, D., Dollarhide, C., Moss, J. (2010). Professional identity development? A grounded theory of transformational tasks of new counselors. *Counselor Education and Supervision*, 50(1), 21-38.

Goodman, L. A., Liang, B., Hems, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist*, 32, 793-837.

Gunn, W., & Blount, A. (2009). Primary care mental health: A new frontier for psychology. *Journal of Clinical Psychology*, 65(3), 235-252.

Hansen, J. T. (2010). Consequences of postmodernist vision: Diversity as the guiding value for the counseling profession. *Journal of Counseling and Development*, 88(1), 101-107.



- Harkness, J., Smith, A., Waxman, D., & Hix, N. (2003). Balancing personal and professional identity: The art of collaborative practice. *Family Systems & Health, 21*(1), 93-99.
- Harris, B. (2009). Extra appendage or integrated service? School counselors reflections. *Counseling and Psychotherapy Research, 9*(3), 174-181.
- Hawkins, P., & Shohet, R. (2000) *Supervision in the Helping Professions, Second Edition*. Buckingham: Open University Press.
- Hays, K., Rardin, D., Jarvis, P., Taylor, N., Moorman, A., & Armstead, C. (2002). Exploratory survey on empirically supported treatments: Implications for internship training. *Professional Psychology: Research and Practice, 33*(2), 207-211.
- Hays, D., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development, 89*, 288-295.
- Herman, J. (1989). The need for a transitional model: A challenge for biopsychosocial medicine? *Family Systems Medicine, 7*, 106-111.
- Hernández, P. (2008). The cultural context model in clinical supervision. *Training and Education in Professional Psychology, 2*(1), 10-17.
- Institute of Medicine (2000). Hurtado, M. P., Swift, E. K., & Corrigan, J. M. Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services, *Envisioning the National Health Care Quality Report*. Washington, DC,: National Academy Press.
- Interprofessional Education Collaborative Expert Panel, (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative.
- Jacobson, T. (2013). Commentary from total health care. *Counseling Today*, October 2013.
- Kaplan, D., & Gladding, S. (2011) A vision for the future of counseling: The 20/20 principles for unifying and strengthening the profession. *Journal of Counseling and Development, (89)*, 367-372.
- Kvale, S., & Brinkmann, S. (2009). *InterViews, Second edition*. Thousand Oaks, California: Sage Publications.
- Levit, K. R., Kassed, C. A., Coffey, R. M., Mark, T. L., McKusick, D. R., King, E., Vandivort, R., Buck, J., Ryan, K., & Stranges, E. (2008). Projections of national expenditures for mental health services and substance abuse treatment 2004–2014. *SAMHSA Publication 08*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Loftus, S. (2009). *Language in clinical reasoning: Towards a new understanding*. Saarbrücken: VDM Verlag.
- Loftus, S., & Higgs, J. (2010). Researching the individual in workplace research. *Journal of Education and Work*, 23(4), 377-388.
- Lopez-Baez, S. I., & Paylo, M. (2009). Social justice advocacy: Community collaboration and systems advocacy. *Journal of Counseling and Development*, 87, 276-283.
- Malin, N., & Morrow, G. (2007). Models of interprofessional working within a sure start 'trailblazer' program. *Journal of Interprofessional Care*, 21(4), 445-457.
- Margalit, A., Glick, S. M., Benbassat, J., & Cohen, A. (2004). Effect of a biopsychosocial approach on patient satisfaction and patterns of care. *Journal of General Internal Medicine*, (19), 485-491.
- Marini, I., & Stebnicki, M. A. (2009). *The Professional Counselor's Desk Reference*. New York: Springer Publishing Company.
- Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*, 140-147.
- Mills, S. D., & Sprenkle, D. H. (1995). Family therapy in the postmodern era. *Family Relations*, 44(4), 368-376.
- Miller, B. F., Teevan, B., Phillips, R. L., Petterson, S. M., & Bazemore, A. W. (2011). The importance of time in treating mental health in primary care. *Family, Systems, and Health*, 29(2), 144-145.
- Moustakas, C. (1994). *Phenomenological research methods*, pp.43-67. Thousand Oaks, California: Sage Publications.
- Myers, J.E., Sweeney, T. J., & White (2002). Advocacy for the counseling profession: Results of a national survey. *Journal of Counseling and Development*. 82(4), 466-472.
- Nelson, M., Johnson, P., & Thorngren, J. (2000). An integrated approach for supervising mental health counseling interns. *Journal of Mental Health Counseling*, 22(1), 45-58.
- Nichols, M. P., & Schwartz, R. C. (1995). *Family Therapy: Concepts and Methods*. Allyn & Bacon, Incorporated.
- North Carolina Department of Health and Human Services Division of Public Health State Center for Health Statistics, January 2012.

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health*. Retrieved from [mentalhealthcommission](http://mentalhealthcommission.gov).

Prior, L. (2003). *Using Documents in Social Research*. Thousand Oaks, California: Sage Publications.

Ray, D., Hull, D., Thacker, A., Pace, L., Swan, K., Carlson, S., & Sullivan, J. (2011). Research in counseling: A 10 year review to inform practice. *Journal of Counseling & Development, (89)3*, 349-359.

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Bebbington, P., et al. (1999). Improving support for mental health staff: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 34(6)*, 309-315.

Roberts, K. T., Robinson, K. M., Stewart, C., & Smith, F. (2009). *An integrated mental health rotation*. *Journal of Nursing Education, 48(8)*. 454-459.

Rossmann, G. B., & Rallis, S. F. (2012). *Learning in the Field: An Introduction to Qualitative Research, Third Edition*. Los Angeles, California: Sage Publications.

Ruddy, N., Borresen, D., & Gunn, W. (2008). *The Collaborative Psychotherapist: Creating Reciprocal Relationships with Medical Professionals*. Washington D.C.: American Psychology Associates.

Scaife, J. (2003). *Supervision in the Mental Health Professions: A Practitioner's Guide*. East Sussex, England: Brunner-Routledge.

Scott, C. (2010). Ecological identity through dialogue. *Canadian Journal of Environmental Education, 135-149*.

Serlin, I., & DiCowden, M. (2007). *Whole person healthcare: Humanizing healthcare. Volume 1*, Praeger.

Shallcross, L. (2013). Total health care. *Counseling Today*, October, 1-5.

Smythe, E., MacCulloch, T., & Charmley, R. (2009). Professional supervision: Trusting the wisdom that 'comes'. *British Journal of Guidance & Counselling, 37(1)*, 17-25.

Sprenkle, D., & Moon, S. (1996). *Research Methods in Family Therapy*. New York, New York: Guilford Press.

Stein, H. F. (1988). Uncomfortable knowledge: An ethnographic clinical training model. *Family Systems Medicine, 6(1)*, 117-128.

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists*. San Francisco: Jossey-Bass Publishers.

Stoltenberg, C.D., McNeill, B., & Delworth, U. (1998). *IDM Integrated Developmental Model for Supervising Counselors and Therapists*. San Francisco: Jossey-Bass Publishers.

Sue, D. W., & Sue, D. (2008). *Counseling for the Culturally Diverse*. Hoboken, New Jersey: John Wiley & Sons.

Sutter, E., McPherson, R., & Geeseman, R. (2002). Contracting for supervision. *Professional Psychology: Research and Practice*, 33(5), 495-498.

Terhune, (2012). Would you want to be a patient in this facility? Case on point: Forum Group. *Nursing Law's Regan Report*, 53(7), 4.

Thomasgard, M., Warfield, J., & Williams, R. (2004). Improving communication between health and infant mental health professionals utilizing ongoing collaborative peer supervision groups. *Infant Mental Health Journal*, 25(3), 194-218.

Tracey, T. J., Ellickson, J. S., & Sherry, P. (1989). Reactance in relation to different supervisory environments and counselor development. *Journal of Counseling Psychology*, 36, 336-344.

Wals, A., & Schwarzin, L. (2012). Fostering organizational sustainability through dialogic interaction. *Education & Competence Studies*, 19(1), 11-26.

Weinrach, S. G., Thomas, K. R., & Chan, F. (2001). The professional identity of contributions to the journal of counseling and development: Does it matter? *Journal of Counseling and Development*, 79(2), 166-170.

Wilber, K. (1998). *A Brief History of Everything*. Boston: Shambhala Publications, Inc.

Zaretsky, L. (2004). Advocacy and administration: From conflict to collaboration. *Journal of Educational Administration*, 42(2), 270-286.

## APPENDIX A: DEMOGRAPHIC FORM/SCREENING QUESTIONS

Date of interview \_\_\_\_\_ Participant Pseudonym \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_

1. What is the highest level of education you have received?
  
2. What type of license or associate license do you currently hold?
  
3. How would you describe your professional affiliation?
  
4. Did you complete your training through a CACREP program?
  
5. How would you describe your practice environment?
  
6. What are the disciplines currently represented on your work team?

## APPENDIX B: INFORMED CONSENT FORM

*Counselor Experience in Interprofessional Collaborative Settings*Project Title and Purpose:

You are invited to participate in a research study entitled Counselor Experience in Interprofessional Collaborative Settings. This is a study to better understand the perceived role of a professional counselor as related to a multi-disciplinary care setting.

Investigator(s):

This study is being conducted by Michelle Kipick Cawn, doctoral candidate, Department of Counseling and Education. Dissertation committee members include Dr. Pam Lassiter (Chair), Dr. Lisa Merriweather (Methodology), Dr. Susan Furr, and Dr. Jack Culbreth.

Description of Participation:

You will be asked to participate in a 60-90 minute semi-structured interview that will be audio taped and transcribed verbatim. Between 12-15 subjects will be asked to participate to help pilot a qualitative inquiry. The information obtained in the interviews will only be used in completion of the dissertation study.

Length of Participation

Your participation in this project will take approximately 10-15 minutes in an initial phone screening and 60-90 minutes in a one session in-person interview. If you decide to participate, you will be one of up 12-15 subjects in this study.

Risks and Benefits of Participation:

There are no known risks to participation in this study. However, there may be risks which are currently unforeseeable. Benefits include the opportunity to offer a professional voice on a topic that impacts mental health delivery.

Possible Injury Statement:

If you are hurt during this study, we will make sure you get the medical treatment you need for your injuries. However, the University will not pay for the medical treatment or repay you for those expenses.

Conflict of Interest:

The investigator does not have a financial interest in the University sponsoring this research (University of North Carolina Charlotte).

Volunteer Statement:

You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may stop at any time. You will not be treated any differently if you decide not to participate or if you stop once you have started.

Confidentiality:

Any information about your participation, including your identity, will be kept confidential to the extent possible. The following steps will be taken to ensure this

confidentiality: voice data will be saved in a secure manner requiring a passcode and transcribed data from the interview will not contain names of the participants. The informed consent will be the only document with a participant name attached and only provided to the professor in charge of data collection.

Fair Treatment and Respect:

UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office (704.687.1871) if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact the Principal Investigator, Michelle Kipick Cawn, at 704-258-5593.

This form was approved for use on, *December 1, 2013* for a period of one (1) year.

Participant Consent

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the Principal Investigator.

\_\_\_\_\_  
Participant Name (PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Investigator Signature

\_\_\_\_\_  
DATE

## APPENDIX C: INTERVIEW GUIDE

*Warm-up/Introduction*

1. How did you hear about this study?
2. What made you want to be involved with this study?
3. Are there any questions that you have before we get started?

*Experience in Interprofessional Collaborative settings*

4. What words would you use to describe your environment?  
-In a multidisciplinary setting?
5. From your perspective how do you define the terms collaborative, integrated, and interprofessional?
6. How are you treated by others on the team?  
-As compared to others, similar, different?  
-How do you see your role on the team?

*Academic readiness*

7. What background knowledge base created an understanding of what it would be like on an integrated team?  
-How do you apply or not apply this knowledge?

*Supervision in IC*

8. What does supervision look like in your setting?  
-How often?  
-By an LPC or other discipline?  
-How do you receive support?

*Final questions*

9. How do you feel about the quality of your work overall?  
-Outcomes?
10. What was it like to describe your experiences working in an interprofessional collaborative care setting?
11. What additional information would you like to share before we conclude the interview?



## APPENDIX D: RECRUITMENT LETTER

Dear Counseling Professional:

My name is Michelle Kipick Cawn and I am a doctoral candidate in the PhD in Counselor Education and Supervision Program at the University of North Carolina Charlotte. I am searching for possible participants for a qualitative, interview-based research study regarding the experiences of licensed professional counselors (LPC's) or licensed professional counselor associates (LPCA's) who currently practice in integrated health settings.

I am recruiting people who are LPC or LPCA professionals who have graduated from a CACREP program, and who are currently practicing in an interprofessional collaborative setting with at least four members representing different disciplines and at least one of the four disciplines representing the medical professional. These could include counselors, marriage and family therapists, social workers, primary health physicians, psychologists, psychiatrists, qualified professionals, psychiatric or primary care nurse practitioners, or physician assistants. Your participation would include one audio-recorded interview that should last 60-90 minutes. The interview will be conducted either in person or by telephone, and all of the questions are concerned with your personal experiences as a mental health counselor working in an integrated setting. There are no wrong answers because the study is all about *your* perceptions and experiences. All of your identifying information will be kept confidential. I will explain in detail if you choose to contact me about the study.

The purpose of this study is to contribute to the field of professional counseling through describing the lived experiences of counselors who currently practice in interprofessional collaborative healthcare settings as related to academic readiness and supervisory needs, to better understand how to support counselors in these environments. If you choose to participate, you will be compensated for your time with a \$25.00 visa gift card.

If you think that you meet the criteria I listed, and you have interest in participating, please contact me via telephone at (704) 258-5593 or email at mcawn@unc.edu. Thank you in advance for your consideration and time.

Sincerely,

Michelle Kipick Cawn