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Shared and Unique Competencies in Interprofessional Behavioral Health: Implications for Counselor Education

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Keywords

professional counselor, interprofessional education, professional identity, professional competencies, behavioral health workforce development

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Behavioral health reform in the U.S. recommends interprofessional education and practice grounded in clinical training in competencies relevant to practice. In tandem, counselor education requires training to learn roles and responsibilities as members of interdisciplinary teams. This pilot explored participants' (N=19) understanding of professional identities and competencies among clinical mental health counseling (CMHC), marriage & family therapy (MFT), psy chiatric mental health nursing (PMHNP) and social work (MSW) students in an interprofessional education (IPE) pr ogram. Participants identified unique profiles of each of the four behavioral health disciplines that align with professions' histories and theoretical orientations as well as a common profile of overlapping skills and knowledge domains across disciplines. The common domains such as assessment, individual intervention, evidence-based practice, and strong oral communication skills, align with overlapping accreditation competencies. Greater common profiling was seen for CMHC, MFT, & MSW versus PMHNP. Our findings indicate implications for counselor education and supervision, and directions for future research.

Keywords

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Behavioral health in the United States (U.S.) is an umbrella term that includes the promotion of wellbeing through prevention, intervention, and treatment of mental health and substance use disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Behavioral health intersects with traditional health care and public health systems, and the federal government is prioritizing integration of all of these systems to improve individual and population-level health outcomes (SAMHSA, n.d.). However, there are challenges to integration, given that access to treatment, treatment delivery, and professionals working within systems have historically been separate and highly fragmented. Historically, psychiatry has "led" mental health treatment through biological perspectives and use of medication, but the "mental hygiene" movement in the U.S. was driven by public health and patient advocacy perspectives (Mandell, 1995). Substance use disorder treatment arose separately from mental health treatment, with influences from self-help movements, morality, and medical lenses (Talchekar, 2022). Behavioral health services most often remain separate from traditional health care and are understaffed, stigmatized, and inaccessible to historically underserved communities because of several factors including insurance limitations and complexities of navigating the system (Mongelli et al., 2020; SAMHSA, 2022). One key opportunity to improve integration and quality of care is through workforce development (Fraher & Brandt, 2019; Hoge et al., 2004; IOM, 2003).

The current landscape of U.S. behavioral health includes various disciplines providing services to the same population of clients, leading to some tension among the professions. Graduate-trained behavioral health professionals in the U.S. include: professional counselors, marriage & family therapists, psychologists, psychiatrists, psychiatric nurse practitioners, and social workers, among others. Each profession has its own professional identity, competencies, historical context, and methods for training students based on discipline specific accrediting

bodies. Of these groups, professional counselors, marriage & family therapists, psychiatric nurse practitioners, and social workers largely enter the workforce with licensure to practice at the master's level.

Various calls to action for augmenting behavioral health care delivery and improving behavioral health outcomes warrant changes in workforce training and development. Such recommendations include moving away from silos and towards greater collaboration and recognition of overlapping scopes of practice (Fraher & Brandt, 2019; Hoge et al., 2009), grounding education and training in competencies and increasing relevance to practice (Hoge et al., 2004; Hoge et al., 2009), and widening definitions of the workforce to include health and behavioral health workers at all levels of education, as well as clients and family members (Fraher & Brandt, 2018; Hoge et al., 2004). On the one hand, experts suggest that educators should break down silos and teach students collaboratively about competencies (skills, knowledge, and professional values) shared between various graduate-level behavioral health professions. Professionals are indeed often working interchangeably in the same jobs despite different behavioral health degrees. Therefore, moving to a model of "the behavioral health professional" to focus on core competencies, reduce confusion, and best meet community needs (Beck et al., 2000) is desirable. This is a conversation that counselor education has often taken the lead on (e.g. Beck et al., 2000) and included a standard to learn the roles and responsibilities of professional counselors in interdisciplinary teams (CACREP, 2016). On the other hand, individual behavioral health professions remain committed to educating students about the unique identities and competencies of their own behavioral health profession, adhering to individual accrediting bodies' standards for guidance. This model focuses on differentiating "roles and responsibilities" (IPEC, 2016) and individual professional identities (McAllister et al., 2014) among the behavioral health professions

and is also seen in accreditation standards that require a course in professional orientation to the field (CACREP, 2016) and legislation that defines professions and scopes of practice (e.g., Department of Public Health, 2023).

We became aware of this tension as we piloted an interprofessional education (IPE) workforce development initiative utilizing a Behavioral Health Workforce Education and Training (BHWET) lens from the Human Resources and Services Administration (HRSA) grant. Our program included master's level students from social work (MSW), clinical mental health counseling (CMHC), marriage and family therapy (MFT), and psychiatric mental health nursing (PMHNP) programs. Our focus was on educating students about integrated care, effective teaming, and evidence-based interventions to meet the needs of underserved communities. Students also had opportunities to interact informally across graduate programs.

This approach was grounded in research supporting the effectiveness of interprofessional education in increasing knowledge, enhancing collaboration, improving communication skills, and enhancing confidence of health professions and social work students (Addy et al., 2015; Cavanaugh & Konrad, 2012; Hovland et al., 2019; Jones et al., 2020; Pare et al., 2012). However, most research on interprofessional education has focused solely on health professions such as medicine, nursing, pharmacy, and so on. There are a few studies that focus on interprofessional mental health training, and those do suggest positive outcomes in attitudes toward teamwork, professional identity, appreciation of diverse worldviews, and communication skills (McAllister et al., 2014; Priest et al., 2011).

In counselor education, there is a history of advocacy for interdisciplinary collaboration in education and clinical practice (Brooks & Gerstein, 1990; Myers et al., 2002). As one of the “youngest” mental health professions, counseling has prioritized intraprofessional identity

development (Klein & Beeson, 2022), and has also spearheaded interprofessional education programs with professions such as speech and language pathology, marriage and family therapy, and social work (Quealy-Berge & Caldwell, 2004; Vereen et al., 2018; Zanskas et al., 2022).

One qualitative study explored the professional identity of professional counselors in practice, and asked participants to differentiate counseling identity from psychology and social work (Mellin et al., 2011). Authors suggest that models exploring distinct and overlapping roles among behavioral health professions would be beneficial to the counseling field as a strategy for addressing role ambiguity and stereotypes that often stand in the way of true interprofessional collaboration. Johnson and Freeman (2014) described ideas for an interprofessional course in a mental health counseling programs and emphasized the need for understanding students' perceptions of interprofessionalism. In line with these recommendations, and in recognition that there is limited research exploring the tension of professional identity development (shared identity versus unique identities) of various behavioral health discipline students when engaged in IPE, we determined that our pilot study will offer an important contribution to the gap in the literature. Our research aim is to explore how master's level students from various behavioral health disciplines, including professional counseling, understand unique and shared professional identities, knowledge, skills and values.

Our specific research question: How do master's level students from various behavioral disciplines understand unique and shared professional identities, knowledge, skills, and values as they enter the workforce?

Methods

This study included a convenience sample of those who participated in a BHWET HRSA grant IPE training. The institutional review board approved the procedure. Students were invited

to participate in the survey about behavioral professional identity and knowledge, skills, and values, by receiving an email from a grant faculty member with a link to the online survey using Qualtrics software. The informed consent indicated that the study was about exploring the professional identity development of graduate students in different behavioral health programs. The researchers clearly articulated that the decision to participate in the survey was completely voluntary and would not impact participants' affiliation with the University nor their relationship with the interprofessional grant programming in any way. Students provided electronic consent to participate at the beginning of the Qualtrics Survey.

Participants

All graduate students (N=22) who participated in the inaugural year of IPE programming were invited to participate in the survey. Three students only completed the demographic questions on the survey and were therefore removed from the sample. The final sample was 19. Students were in the final year of the CMHC, MFT, MSW, and PMHNP graduate programs and were all participating in final internship experiences concurrent with the monthly interprofessional training sessions. Of the 19 participants 5 were CMHC, 3 were MFT, 9 were MSW, and 2 were PMHNP. All four programs were accredited by discipline specific accreditation bodies. Participants included 2 males, 16 females, and 1 non-binary. The ethnic composition included 9 White, non-Hispanic, 5 Black, 4 Hispanic, and 1 Asian. The mean age of participants was 31.89 years and the mean number of years in mental health, addictions, and/or social service fields was 2.47. Additional socio-demographic characteristics of participants are provided in Table 1.

Table 1
Participant Characteristics

Socio-demographics	**Frequency (%) or M (SD)** N=19
Profession	
CMHC	5 (26.32%)
MFT	3 (15.79%)
MSW	9 (47.37%)
PMHNP	2 (10.53%)
Race/ethnicity	
Asian	1 (5.26%)
Black	5 (26.32%)
Hispanic	4 (21.05%)
White, Non-Hispanic	9 (47.37%)
Gender identity	
Female	16 (84.21%)
Male	2 (10.53%)
Non-binary	1 (5.26%)
Age (years)	Range: 24 -52 31.89 (9.94)
Experience in mental health, addictions, and/or social services (years)	2.47 (1.43)

Measures

Participants completed both an adapted Professional Identity Scale in Counseling and a Behavioral Health Professional Skills, Knowledge, and Values Inventory in addition to a demographic survey. We gathered ratings of professional uniqueness and professional collaboration from the adapted Professional Identity Scale in Counseling. We gathered information about both unique and shared components of professional identities through the Behavioral Health Professional Skills, Knowledge, and Values Inventory. The demographic survey helped with describing the population that we surveyed.

Adapted Professional Identity Scale in Counseling

The Professional Identity Scale in Counseling (PISC; Woo & Henfield, 2015) is one of the most commonly used measures of professional identity in the counseling profession and was adapted for use in this study. Given the research question examining interprofessional behavioral health identity, the first two authors focused on Factor 5: Philosophy of the Profession and Factor 6: Professional Values, and adapted these questions for additional behavioral health professions examined (MSW, MFT, PMHNP). In addition, we removed two questions (#49. *Research is an important part of the counseling profession*; #52. *I would like to be more involved in professional development activities*) which we did not believe were essential to our core exploration into the participants' identification of shared knowledge, skills, and values. Also, given our current research aim, we created a question on collaboration with other mental health professionals (*The ____ profession routinely collaborates with other professionals in clinical practice*.) All items were rated on a Likert type rating scale of 1-5 (1= strongly disagree, 5=strongly agree).

Behavioral Health Professional Skills, Knowledge, & Values Inventory

Inventory Development. We were unable to find a measure of behavioral health professional skills, knowledge, and values in the literature. Therefore, we developed an inventory using key informants from the disciplines included in the study.

The first two authors (from MSW & CMHC disciplines) developed a list of 25 items based on their own clinical and teaching expertise. These authors have an average of over 20 years of experience in their respective disciplines and are involved in their professional organizations. We then sent the list of items out to three faculty experts from PMHNP & MFT disciplines, who had an average of over 30 years of experience in their respective disciplines. The communication to experts indicated that we were creating a list of competencies (knowledge/skills) that are at the

core of the four disciplines (CMHC, MFT, MSW, and PMHNP). We requested that they add items that were core to their professions but not yet in the list of 25 items. These faculty experts added a total of 46 additional items.

Researchers reviewed the final summative list of 71 items individually to identify repetitive or overlapping competencies, as well as items that were overly specific (rather than general categories of knowledge or practice). Co-researchers then met to review and revise. There was a high degree of consensus. The minor differences were discussed and analyzed until consensus was reached. For instance, decisions were made jointly about removing overly specific concepts (e.g., Porges polyvagal theory) or rewording concepts to be more inclusive (e.g., racial equity, anti-racism, white privilege, & privilege were collapsed into the category of racial equity).

Behavioral Health Professional Skills, Knowledge, and Values Inventory (PSKV). The final inventory included the same 27 items (See Table 2) for each of the four disciplines (CMHC, MFT, MSW, and PMHNP) with a Likert type rating scale of 1-5 (1= not integral, 5=very integral).

Data Analysis

Descriptive statistics including frequencies, percentages, means, and standard deviations were computed for survey items and participant socio-demographic characteristics.

Results

Unique Professional Identities

Means and standard deviations were calculated for each item (by profession) in the Behavioral Health Professional Knowledge, Skills and Values Inventory. These scores are provided in Table 2. Highest mean scores for each profession were identified to create a profile of unique professional identities. See Table 3 for unique profiles.

Table 2

PSKV Items with Highest Rating by Disciplines

Items from PSKV Inventory	***CMHC*** *M (SD)*	***MFT*** *M (SD)* *N=13*	***MSW*** *M (SD)*	***PMHNP*** *M (SD)*
Strong oral communication+*	*4.44 (1.06)* *N=15*	*4.54 (.63)*	*4.57 (.62)* *N=14*	*4.41 (.79)* *N=12*
Assessment+*	*4.38 (.70)* *N=16*	*4.23(.8)*	*4.60 (.74)* *N=15*	*4.17 (.90)* *N=12*
Cultural competence+	*4.53 (.72)* *N=16*	*4.46 (.63)*	*4.73 (.57)* *N=15*	*3.85(.77)* *N=13*
Evidence based practice+*	*4.44 (.70)* *N=16*	*4.31(.72)*	*4.36(.61)* *N=14*	*4.17 (.80)* *N=12*
Racial equity+	*4.31(1.1)* *N=16*	*4.46 (.63)*	*4.67 (.60)* *N=15*	*3.85(.77)* *N=13*
Research on efficacy of treatment+*	*4.38 (.70)* *N=16*	*4.31(.72)*	*4.21(.67* *N=14*	*4.25 (.92)* *N=12*
Telehealth skills+*	*4.19(.95)* *N=16*	*4.38 (.74)*	*4.07(.96)* *N=14*	*4.17 (.90)* *N=12*
Trauma informed practice+*	*4.50 (.71)* *N=16*	*4.31(.91)*	*4.53 (.72)* *N=15*	*4.08(1.19)* *N=12*
Wellness+*	*4.38 (.78)* *N=16*	*4.15(.95)*	*4.47(.72)* *N=15*	*4.23 (.89)* *N=13*
Crisis intervention+	*4.38 (.70)* *N=16*	*4.15(.66)*	*4.40(.71)* *N=15*	*3.92(1.19)* *N=12*

Expertise: psychotropic meds	*3.38(.99) N=16*	*2.92(1)*	*3.40(.8) N=15*	*4.38 (.92) N=13*
Family interventions	*3.76(1.03) N=16*	*4.69 (.61)*	*4.47(.62) N=15*	*3.25(.72) N=12*
Individual interventions+*	*4.31(.77) N=16*	*4.15(.77)*	*4.60 (.71) N=15*	*4(.91) N=12*
Group interventions	*3.94(1.09) N=16*	*4.31(.91)*	*4.2(.65) N=15*	*2.83(.69) N=12*
Interventions: Organizations/ Communities	*4.13(.99) N=16*	*3.69(1.14)*	*4.29(.88) N=14*	*3.83(.9) N=12*
Person centered approach+	*4.63 (.60) N=16*	*4.23(.8)*	*4.57(.62) N=14*	*3.75(.83) N=12*
Social justice advocacy	*3.95(1.3) N=16*	*4.08(1.14)*	*4.60 (.71) N=15*	*3.23(.97) N=13*
System approach to mental health	*3.94(.75) N=16*	*4.69 (.61)*	*4.07(.85) N=15*	*3.46(1.01) N=13*
Therapist use of self+	*4.38(.6) N=16*	*4.46 (.63)*	*4.13(.72) N=15*	*3.33(.85) N=12*
Developmental approach+*	*4.31(.92) N=16*	*4.54(.63)*	*4.4(.71) N=15*	*4.08(.83) N=12*
Ecological model+	*4.31(.92) N=16*	*4.31(.72)*	*4.4(.71) N=15*	*3.69(.99) N=13*
Diagnosis (e.g. DSM 5)	*4.25(.97) N=16*	*3.85(.77)*	*4.2(.75) N=15*	*4(.88) N=13*

Prevention work	*4.13(1.17) N=16*	*3.92(1.07)*	*4.21(.94) N=14*	*4(.91) N=12*
Public Health issues	*4(1.06) N=16*	*3.46(1.15)*	*4.21(.77) N=14*	*4(1.08) N=12*
Evaluation of treatment+	*4.25(.75) N=16*	*4.15(.77)*	*4.29(.7) N=14*	*3.58(1.04) N=12*
Leadership in mental health	*3.88(1.05) N=16*	*3.77(.8)*	*4.21(.77) N=14*	*4(.82) N=12*
Expertise in substance use disorders	*4.19(.81) N=16*	*3.77(.8)*	*4(.65) N=14*	*4.08(.76) N=12*

*Note: * indicates those items common for all 4 disciplines (M=4.0 or above); + indicates those items common for CMHC, MFT, & MSW (M=4.0 or above)*

Table 3

Unique Professional Identity Profiles per Discipline (PSKV items with highest mean scores)

Most integral to CMHC M(SD), N= 16	**Most integral to MFT** M(SD), N= 13	**Most integral to MSW** M(SD), N=15	**Most integral to PMHNP** M(SD), N=13
Person-centered approach **4.63(.6)**	Systems approach to tx **4.69(.61)**	Cultural competence **4.73(.57)**	Expertise: psychotropic meds **4.69(.61)**
Cultural competence **4.53(.72)***	Family interventions **4.69(.61)**	Racial equity **4.67(.6)**	Strong oral communication **4.69(.61)***
Trauma- informed practice **4.5(.71)**	Strong oral communication **4.54(.63)**	Social justice advocacy **4.6(.71)**	Research: efficacy of tx **4.54(.63)***
Strong oral communication **4.44(1.06)**	Racial equity **4.46(.63)**	Assessment **4.6(.74)**	Wellness **4.46(.63)**
Evidence-based practices **4.44(.7)**	Cultural competence **4.46(.63)**	Individual intervention **4.6(.71)**	Evidence-based practice **4.46(.63)***
Wellness **4.38(.78)**	Therapist use of self **4.46(.63)**	Strong oral communication **4.57(.62)***	Telehealth skills **4.46(.63)***

Assessment **4.38(.7)**	Telehealth skills **4.38(.74)**	Trauma-informed practice **4.53(.72)**	Assessment **4.38(.74)***
Crisis intervention **4.38(.7)**			
Research: efficacy of tx **4.38(.7)**			

*N=15 for this item *N=14 for this item *N=12 for these items

Common Factors across Behavioral Health Disciplines

A profile of common factors across behavioral health disciplines was created by identifying all items that were rated by participants at "4" or higher across all disciplines. A score of "4" indicates agreement that an item is integral to a profession.

Nine, or 33.3% of all items, had mean scores of 4.0 or above across all four disciplines. The profile of "common factors" includes: wellness; developmental approach; assessment; individual interventions; trauma-informed practice; telehealth skills; research on efficacy of treatment; evidence-based practice; and strong oral communication.

Sixteen, or 59% of all items, had mean scores of 4.0 or above for three of the professions: CMHC, MFT, & MSW. These include: racial equity; cultural competency; wellness; developmental approach; ecological model; therapist use of self; assessment; individual interventions; trauma-informed practice; crisis intervention; telehealth skills; person-centered approach; research on efficacy of treatment; client-based evaluation of practice; evidence-based Practice; and strong oral communication.

Ratings of Uniqueness and Collaboration

Looking at professional identity from another perspective, using the PISC scale, two items stood out as being most relevant to our research aims: professional uniqueness and collaboration. Results are reported below by professional subgroups in Table 4. Mean scores on professional

uniqueness ranged from 4 - 4.44, while mean scores on collaboration ranged from 3.67 - 5 (5 = strongly agree).

Table 4
Ratings of Collaboration and Uniqueness

Profession	My profession routinely collaborates in clinical care Mean (SD), 5 pt scale	My profession is different from other mental health professions Mean, 5 (SD) pt scale
MSW (N=9)	4.33 (.82)	4.44 (.50)
MFT (N=3)	3.67 (.47)	4.33 (.47)
CMHC (N=5)	4.20 (.75)	4.0 (.89)
PMHNP (N=2)	5.00 (.00)	4.00 (.00)

Discussion

We asked master's level students in CMHC, MFT, MSW, and PMHNP about their perceptions of knowledge, skills, and values integral to various behavioral health professions. Participants had limited experience in the behavioral health/ social service fields, with the mean number of years being 2.47. Participants had exposure to IPE but the majority of their education occurred within traditional, uni-professional classroom spaces. It is also worth noting that the majority of students were female-identified (84%) and approximately half were White (47%). Forty-seven percent of the sample were MSW students, 26% were CMHC students, 16% were MFT students and only 10.5% were PMHNP students. While we interpret pilot data with caution, participants clearly identified unique profiles of each behavioral health profession, while also suggesting that there are common professional and therapeutic skills across disciplines.

Unique profiles seem to differ mainly based on theoretical orientations and history of practice in the U.S. For example, the professional profile for CMHC includes "wellness" and "person-centered approach," which aligns with core theoretical frameworks of the profession. Alternately, the professional profile for MSW includes "racial justice" and "social justice advocacy," which align with social work's history and emphasis on community-based macro practice. MFT is defined by systems and family interventions, in keeping with the profession's unique focus on families and couples. PMHNP profile highlights expertise in psychotropic medication, which aligns with the profession's health care roots and the ability to prescribe medication. Interestingly, systems skills are only identified as being core to the MFT profession by our participants although listed in accreditation standards for CMHC, MSW, and PMHNP. Possibly, participants are influenced by the most common or most often taught theoretical orientations as they respond to these questions.

In our attempt to better understand the results, we turned to educational competencies for individual professions. For the convenience of the reader, we have provided the competencies for CMHC (Council for Accreditation of Counseling and Related Educational Programs [CACREP]), MFT (Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE]), MSW (Council on Social Work Education [CSWE]) and PMHNP (National Organization of Nurse Practitioner Faculties [NONPF]) in Table 5. While we see significant overlap, such as in the areas of ethics, research, and clinical care delivery, the professional knowledge, skills, and values are framed differently by different accreditation bodies. Disciplinary specific language and framing may be a reason that participants did not identify all competencies relevant to a profession (as listed in accreditation standards) and point to the complexities of professional identity.

Table 5

Individual Professional Competencies (Knowledge, Values & Skills)

CMHC CACREP Competencies (Foundation, Context, and Practice)	**MFT COAMFTE Competencies**	**MSW CSWE Competencies**	**PMHNP NONPF Competencies**
Professional Counseling Orientation and Ethical Practice	Admission to Treatment	Demonstrate ethical & professional behavioral	Scientific foundation
Social and Cultural Diversity	Clinical Assessment and Diagnosis	Advance human rights & social, racial, economic, & environmental justice	Leadership
Human Growth and Development	Treatment Planning and Case Management	Engage anti-racism, diversity, equity, & inclusion in practice	Quality
Career Development	Therapeutic Intervention	Engage in practice-informed research & research-informed practice	Practice inquiry
Counseling and Helping Relationships	Legal Issues, Ethics, and Standards	Engage in policy practice	Technology & Information literacy
Group Counseling and Group Work	Research and Program Evaluation	Engage w/ individuals, families, groups, organizations & communities	Policy
Assessment and Testing		Assess individuals, families, groups, organizations & communities	Health delivery system
Research and Program Evaluation		Intervene w/ individuals, families, groups, organizations & communities	Ethics
		Evaluate practice w/ individuals, families, groups, organizations & communities	Independent practice

It is noteworthy that the core common skills that participants identified, which included professional and therapeutic skills, such as assessment, individual intervention, evidence-based

practice, and strong oral communication skills, align with overlapping accreditation competencies, although the participant generated profile does not completely identify all overlap. Additionally, some behavioral health fields have more overlap than others with cultural competence and racial equity, identified by participants as core for CMHC, MSW, and MFT, but not for PMHNP. Perhaps, because these three programs are located within the same school in this particular university, collaboration in training may have trumped developing distinct identities.

Although behavioral health in the U.S. includes the promotion of wellbeing and prevention and treatment of mental health and substance use disorders (SAMHSA, n.d.) of note, neither substance use disorder treatment nor leadership were rated highly by participants as being integral to any of the included behavioral health professions. Integration of substance abuse disorder competencies into master's level behavioral health programs is a priority for systems transformation (e.g. Estreet & Gomez, 2022) and may be an area for further curricular review (both in individual graduate programs and in interprofessional training). Leadership has also been identified as important for behavioral health professionalization and integrated, team-based care (Yamada et al., 2019; Berrett-Abebe et al., 2021). However, it may be that leadership is on a developmental trajectory, with students (i.e., our participants) less likely to identify as leaders than clinicians working in the field. This might present an opportunity for integrated behavioral health curricular development on a continuum from master's level education programs to ongoing workforce development.

While mean scores across professions on the item "My profession is different from other mental health professions," are all fairly high, ranging from 4-4.4, mean scores on the item "My professional routinely collaborates in clinical care" range more widely, from 3.7 (MFT) - 5 (NP). The uniformly high scores on professional identity differences may reflect the fact that master's

level programs largely still train students in silos, socializing students into their own professions. In fact, various professions have historically worked in different settings, with different models of care. For example, nurses tend to work in medical settings where team-based collaboration is now the norm, where as individual outpatient mental health practice is typical for MFTs. However, it is difficult to draw any firm conclusions, given the small sample size in this study's subgroups.

Limitations and Future Directions

We acknowledge several limitations, including a small sample size, with a particularly small number of PMHNP participants (2) and MFT participants (3) in proposing our conclusions and abstain from generalizing based on our findings. Additionally, the sample is from one private, mid-sized, predominantly white University on the east coast. We are aware that there are regional behavioral health workforce differences in the U.S. based on the historical development of professions and professional education programs as well as differing state legislation. These limitations point to future directions for research, such as studies with larger sample sizes across various regions of the U.S. It also would be illuminating to explore the topic of shared versus unique behavioral health professional identities across different countries and different models of health care delivery.

Implications for Counselor Education and Supervision

Despite limitations, this research has important implications for behavioral health education and practice broadly, and counselor education more specifically. Our pilot data suggests that master's level students in behavioral health disciplines are able to recognize uniqueness and commonalities across their professions, although graduate level education largely continues in silos, despite overlapping knowledge, skills, and values. It will be helpful for counselor educators to acknowledge both the counseling field's unique professional identity as well as common factors

across behavioral health professions in preparing students for the practice landscape, in which professionals are often working collaboratively and/or interchangeably. This can be accomplished both through coursework and intentional infusion of team and professional identities into practice-based training and is in line with conclusions from previous research on counselor professional identity (Klein & Beeson, 2022; Mellin et al., 2011). Given that counseling is one of the few professions that allows counselors-in-training to be supervised by other licensed behavioral health professionals, these students would benefit from the opportunity to understand interdisciplinary perspectives before they are placed in team work settings. Counselor education faculty can use time in their clinical courses to expand on these perspectives, to allow students to build on their unique identities while understanding the similarities among professions, reducing the confusion at early stages in the workforce. Professional counseling supervisors may also have unique opportunities to explore concepts of identity, roles, and scope of practice with trainees in "real time" in the field. It is important to intentionally discuss professional roles and responsibilities as a regular part of the supervision experience to reduce anxiety and increase counselor-in-training awareness and ability to negotiate their own roles and responsibilities in inter disciplinary teams (CACREP, 2016). Promotion of interprofessional education in the classroom and practice spaces can complement uni-professional education programs, and aligns with CACREP (2016) standards. These adaptations have the potential to improve client care, as counselors and other behavioral health providers develop enhanced teaming skills and are able to more explicitly articulate their own orientations and skills.

Based on study results, we see the merit of Beck et al.'s (2000) suggested creation of a unified "master's level behavioral health professional specialist" designation that acknowledges shared, core behavioral health professional competencies. Such a designation might lead to better

alignment of behavioral health profession education and improve access for consumers by increasing transparency and reducing confusion. However, as this study makes clear, there is value in such a designation coming alongside (not replacing) unique behavioral health professions, such as professional counseling. The unique theoretical approaches and histories of behavioral health professionals can offer various perspectives on teams as well as tailored care to clients.

We suggest further research on interdisciplinary teams with larger and varied sample, as well as in other regions, to determine how each field negotiates their roles and responsibilities. In addition, examination of the issues such interdisciplinary teams bring to both the providers and the clients would benefit all behavioral health disciplines.

Conclusion

We advocate for more conversations about unique and shared identities as well as more IPE at all levels of training to landscape a more intentional behavioral health workforce to meet community needs. There are also opportunities to infuse IPE in required continuing education for counseling professionals that may be beneficial to advance behavioral health services. This study also highlights the challenge of training behavioral health professionals for the reality of delivery of these services in a healthcare system that frequently does not distinguish between disciplines. Graduates must learn "on the job" about the various professionals who participate in behavioral health client care and where they themselves fit into that system. Therefore, it is not a surprise that clients seeking treatment in the U.S. are at a loss as to how to access and receive the best care. This continues to perpetuate the crisis of overwhelming behavioral health needs with inadequate targeted treatment. We hope this initial exploration of professional identity factors in different disciplines will be a stepping stone to clarifying behavioral health professional roles, both individually and collectively, which could result in greater clarity for the general public seeking

behavioral health services. We need a strategic “both-and” approach of uni and inter-professional education for behavioral health trainees broadly, and counseling students specifically. Preparation for and understanding of integrated practice and systems will benefit both new professionals and clinical services overall.

References

Addy, C. L., Browne, T., Blake, E. W., & Bailey, J. (2015). Enhancing interprofessional education: Integrating public health and social work perspectives. *American Journal of Public Health, 105*(S1), S106-S108. http://dx.doi.org/10.2105/AJPH.2014.302502

Beck, E. S., Kaplan, D., Smith, H., & Moroco, J. (2000). The behavioral health professional: a mental health professional identity model for the 22nd century. *Counseling and Human Development*, *33*(4), 1-10.

Berrett-Abebe, J., Padykula, N., Clark, M., Zenevitch, R., Bjorklund, D., Gentile, M., Ward, K., & Haven, T. J. (2021). Social work student reflections on training in integrated care: opportunities for social work educators. *Social Work Education*, 1-17. http://dx.doi.org/10.1080/02615479.2021.1976137

Brooks, D. K., Jr., & Gerstein, L. H. (1990). Counselor credentialing and interprofessional collaboration. *Journal of Counseling & Development, 68*(5), 477-484. http://doi.org/10.1002/j.1556-6676.1990.tb01394.x

Cavanaugh, J. T., & Konrad, S. C. (2012). Fostering the development of effective person-centered healthcare communication skills: an interprofessional shared learning model. *Work, 41*(3), 293-301. http://dx.doi.org/10/3233/WOR-2012-1292

Council for Accreditation of Counseling and Related Educational Programs. (2016). *2016 standards*. www.cacrep.org

Department of Public Health. (2023). *Professional counselor licensure requirements.* https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Professional-Counselor/Professional-Counselor-Licensing-Requirements

Estreet, A., & Gomez, R. J. (2022). The CSWE substance use curricular guide: inception, evolution, impact. *Journal of Social Work Practice in the Addictions*, *22*(2), 169-174. http://dx.doi.org/10.1080/1533256X.2021.1993119

Fraher, E., & Brandt, B. (2019). Toward a system where workforce planning and interprofessional practice and education are designed around patients and populations not professions. *Journal of Interprofessional Care, 33*(4), 389-397. http://dx.doi.org/10.1080/13561820.2018.1564252

Hoge, M. A., Huey, L. Y., & O'Connell, M. J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health and Mental Health Services Research, 32*(2), 91-106. https://doi.org/10.1023/B:APIH.0000042742.45076.66

Hoge, M. A., Morris, J. A., Stuart, G. W., Huey, L. Y., Bergeson, S., Flaherty, M. T., Morgan, O., Peterson, J., Daniels, A. S., Paris, M., & Madenwald, K. (2009). A national action plan for workforce development in behavioral health. *Psychiatric Services, 60*(7), 883-887. http://dx.doi.org/10.1176/ps.2009.60.7.883

Hovland, C. A., Whitford, M. & Niederriter, J. (2019). Interprofessional education for social work students: findings from a cross-sectional study. *Journal of Baccalaureate Social Work, 24*(1), 85-103. http://dx.doi.org/10.18084/1084-7219.24.1.85

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. The National Academies Press.

Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update*. Interprofessional Education Collaborative, Washington, DC.

Jones, B., Currin-McCulloch, J., Petruzzi, L., Phillips, F., Kaushik, S., & Smith, B. (2020). Transformative teams in health care: Enhancing social work student identity, voice, and leadership in a longitudinal interprofessional education (IPE) course. *Advances in Social Work, 20*(2), 424-439. http://dx.doi.org/10.18060/23671

Johnson, K. F., & Freeman, K. L. (2014). Integrating interprofessional education and collaboration competencies (IPEC) into mental health counseling education, *Journal of Mental Health Counseling*, *36*(4), 328-344. https://doi.org/10.17744/mehc.36.4.g47567602327j510

Klein, J., & Beeson, E. (2022). An exploration of clinical mental health counselors' attitudes toward professional identity and interprofessionalism. *Journal of Mental Health Counseling*, *44*(1): 68–81. https://doi.org/10.17744/mehc.44.1.06

Mandell, W. (1995). Origins of mental health: Realization of an idea. https://publichealth.jhu.edu/departments/mental-health/about/origins-of-mental-health (accessed 11 December 2022)

McAllister, M., Statham, D., Oprescu, F., Barr, N., Schmidt, T., Boulter, C., Taylor, P., McMillan, J., Jackson, S., & Raith, L. (2014). Mental health interprofessional education for health professions students: bridging the gaps" *The Journal of Mental Health Training, Education and Practice, 9*(1), 35-45. http://dx.doi.org/10.1108/JMHTEP-09-2012-0030

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*, *89*(2), 140-147. https://doi.org/10.1002/j.1556-6678.2011.tb00071.x

Mongelli, F., Georgakopoulos, P., & Pato, M.T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States, *Focus*, *18*(1), 16-24. https://doi.org/10.1176/appi.focus.20190028

Myers, J. E., Sweeney, T. J., & White, V. E. (2002). Advocacy for counseling and counselors: A professional imperative. *Journal of Counseling & Development, 80*(4), 394-402. https://doi.org/10.1176/appi.focus.20190028

Paré, L., Maziade, J., Pelletier, F., Houle, N., & Iloko-Fundi, M. (2012). Training in interprofessional collaboration: pedagogic innovation in family medicine units. *Canadian Family Physician, 58*(4), e203-e209. PMID: 22611607; PMCID: PMC3325472

Priest, H., Roberts, P., Dent, H., Hunt, T., Weston, D., Chell, A., Blincoe, C., & Armstrong, C. (2011). Preparing for collaborative working in mental health: An interprofessional education project with clinical psychology trainees and nursing students. *The Journal of Mental Health Training, Education and Practice*, *6*(1), 47-57. http://dx.doi.org/10.1108/17556221111136161

Quealy-Berge, D,. & Caldwell, K. (2004). Mock interdisciplinary staffing: Educating for interprofessional collaboration. *Counselor Education and Supervision, 43*, 310-320. https://doi.org/10.1002/j.1556-6978.2004.tb01855.x

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). SAMHSA – Behavioral health integration. https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf (accessed 11 December 2022)

Substance Abuse and Mental Health Services Administration (SAMHSA) (2022). Behavioral health equity. https://www.samhsa.gov/behavioral-health-equity

Talchekar, A. (2022). Timeline: History of addiction treatment. https://recovery.org/drug-treatment/history/

Vereen, L.G., Yates, C., Hudock, D., Hill, N. R., Jemmett, M., O'Donnell, J., & Knudson, S.

(2018). The phenomena of collaborative practice: The impact of interprofessional education. *International Journal of Advanced Counselling 40*, 427–442. https://doi.org/10.1007/s10447-018-9335-1

Woo, H., & Henfield, M. S. (2015), Professional identity scale in counseling (PISC): Instrument development and validation. *Journal of Counselor Leadership and Advocacy*, *2*(2), 93-112. http://dx.doi.org/10.1080/2326716X.2015.1040557

Yamada, A. M., Wenzel, S. L., DeBonis, J. A., Fenwick, K. M., & Holguin, M. (2019). Experiences of collaborative behavioral health-care professionals: Implications for social work education and training. *Journal of Social Work Education*, *55*(3), 519-536. http://dx.doi.org/10.1080/10437797.2019.1593900

Zanskas, S., Brasfield, M., Landry, M., Taylor, L., Delavega, E., & Neely-Barnes, S. (2022). Interprofessional training: Preparing graduate counseling and social work students for integrated behavioral healthcare Settings, *Journal of Evidence-Based Social Work, 19*(3), 314-330, http://dx.doi.org/10.1080/26408066.2022.2049944