



**Integrated Health Psychology Training Program
Final Report – Evaluation Findings
2004-2010**



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EXECUTIVE SUMMARY

Overview

In 2010, the Wright Institute's *Integrated Health Psychology Training Program (IHPTP)*, engaged fdcPartnerships to assess its progress towards the following goals: 1) improve care to health consumers; 2) prepare an emerging psychology workforce to provide behavioral health services in medical settings; and 3) promote collaboration between psychologists and other health services providers. This report provides a description of IHPTP, an overview of the evaluation methodology, summary of findings compiled from various data sources, and recommendations for programmatic improvement and refinement.

Summary of Findings

Health Consumer Impact

- The professional expertise provided by an IHPTP student is one component of a team of health professionals that work to decrease health related issues for patients.
- Students provide therapeutic and economic benefits that increase patient wellbeing.
- Treatment coordinated across providers, students, and social workers and incorporating social service resources for basic needs such as food, housing, and employment is most beneficial for health consumers in these clinics.

Student Impact

- The IHPTP program provides comprehensive behavioral health training that allows aspiring clinicians opportunities to hone vital skills that respond to the needs of highly underserved populations.
- Students' practicum experiences allow them opportunities to engage with individuals from different ethnic, economic, and educational backgrounds.
- Trainings are able to equip students with knowledge about common behavioral health issues; the anxieties involved in a new transitioning into a new professional role are decreased through experience.
- Graduates of the IHPTP program are more likely to pursue careers working in an integrated health setting.
- Students provide important psychotherapeutic treatment that is valued by clinic partners and health consumers.

Promotion of Interdisciplinary Collaboration Program Model

- IHPTP has successfully developed a reputation with clinic partners that value the benefits of an integrated team model.
- Clinic partners with limited expertise in behavioral health appreciate and draw on the professional knowledge brought by trainees to aid in treatment planning and exploration of medical non-compliance.
- The presence of trainees allows health professionals the opportunity to maximize client visits and through partnerships, they are able to capitalize on other billing opportunities.
- Clinical champions or onsite mentors are essential in increasing engagement between trainees and their colleagues.

BACKGROUND

The Wright Institute's *Integrated Health Psychology Training Program* (IHPTP), places doctoral level clinical psychology students in surrounding community health centers to deliver psychological and behavioral health services to uninsured and underserved patients presenting with a multitude of health-related problems. Currently IHPTP is in its 6th year of implementation and its third and final year of federal funding and seeks to understand the impact of its comprehensive behavioral health-training program.

Evaluation Questions

To guide the evaluation, a set of questions was developed with IHPTP and which informed the data collection methods and tools. Following are the questions organized by focus areas:

- **Health Consumer Impact**
 - To what extent are there improvements in consumer general health?
 - To what extent is there a decrease in psychological and health symptoms among FOHC consumers?

- **Student Impact**
 - To what extent are trainings effective in increasing trainee knowledge etiology, prevention, diagnosis and treatment of physical and mental illness?
 - To what extent is supervision adequate for psychological intervention?

- **Promotion of Interdisciplinary Collaborative Model**
 - In what ways are trainees and other health service providers collaborating on patient care?
 - To what extent are these collaborations increasing and/or improving?
 - To what extent are trainees providing behavioral health services in FOHC centers?
 - In what ways does IHPTP add value to the clinics?

Methods

In outlining an overarching frame and focus for IHPTP's evaluative inquiry, existing data collection tools and methods were reviewed by IHPTP staff and jdcPartnerships. Key tools were identified and refined to better align with programmatic goals, and additional evaluative methods and tools were designed and administered to describe program impact.

In order to provide a holistic view of the IHPTP program, jdcPartnerships and IHPTP identified and queried key stakeholders able to provide insight into the questions outlined above. Both quantitative and qualitative data collection methods were used to conduct this evaluation. This provided a rich array of data sources representing the voices and experiences of medical providers, past IHPTP trainees, administrative partners, and 2009-10 IHPTP trainees. The following table summarizes the various methods used.

Figure 1: Evaluation Data Collection Methods Summary

Data Collection Strategy	Data Source	Sample Size	Description	Data Collection Completed
Surveys	Program Completers Survey	18	2004-05 to 2008-09 IHPTP trainees described impact of program over time	March 2010 – April 2010
	Student Year-End Survey	8	2009-10 IHPTP Trainees	August 2010
Interview	Medical Provider	6	IHPTP interdisciplinary partners	August 2010-September 2010
Focus Group	Social Workers	5	IHPTP interdisciplinary partners	September 2010
Student Performance Data	Current student weekly consultation logs	8 IHPTP Trainees completed 209 logs	Documentation of services provided	September 2009 – May 2010

Program Completers Survey

IHPTP staff provided contact information for former trainees who were contacted via email by the program's Clinical Liaison prior to the survey administration. More than one-half (56%) of IHPTP's former trainees (2004-05 to 2008-09) completed an online Retrospective Survey (See Appendix A for summary of survey findings). The survey was designed to capture information about the experiences and long-term impact of the IHPTP training program as shared by graduates.

Student Year-End Survey

2009-10 IHPTP trainees also completed an on-line survey. As with the Program Completer Survey, the program's Clinical Liaison contacted students via email prior to the survey's release. All of the 2009-2010 IHPTP trainees completed the survey for a 100% response rate. This survey was designed to capture information about their practicum experiences, the effectiveness of the IHPTP training curriculum, as well as how the program has influenced their future career aspirations. (See Appendix A for survey summary of findings).

Individual Medical Provider Interview

Individual medical providers were identified by IHPTP Clinical Liaison and invited to by jdcPartnerships to complete a 30-minute key informant telephone interview. Six medical providers (67% response rate) across different partnering organizations shared feedback that broadly focused on the presence of and pathways to interdisciplinary collaboration, the impact that trainees' expertise has had in treatment planning and patient outcomes, and recommendations for programmatic improvement.

Social Worker Focus Group

Five social workers of the LifeLong Medical Care Organization's current placement clinics participated in a 90-minute focus group that examined student integration and impact. Two upcoming site partners for the 2010-2011 academic year were also present for this discussion.

Student Weekly Logs

2009-10 IHPTP trainees were asked to complete weekly logs documenting opportunities and requests for clinical services. A summary of 209 individual logs produced by the eight 2009-2010 IHPTP trainees were reviewed to obtain information about the frequency and type of presenting issues, time spent completing consultations, source of referral, requests for consultation and the tools used to provide behavioral health services in their respective sites. (See Appendix A for Summary)

PROGRAM OVERVIEW

The Wright Institute's *Integrated Health Psychology Training Program* (IHPTP) places Clinical Psychology doctoral level students in surrounding community health centers to deliver psychological and behavioral health services to uninsured and underserved patients. Trainees are eligible to apply for practicum placement during their 2nd year of study. For the past several years The Wright Institute has developed relationships with the following clinics: 1) Berkley Primary Care Access Clinic, 2) West Berkeley Family Practice, 3) East Oakland Clinic, 4) Tri-City Health Center 5) Downtown Oakland Clinic 6) Glide Health Services. Upon completion of an application and interview process, students are ranked by clinics partners based on fit and other criteria specific to the clinic. Students are assigned to a partnering organization to complete a nine-month practicum experience. Table 2 provides a summary of collaborative organizations that have hosted IHPTP trainees over the last 6 years.

Figure 2: IHPTP Practicum Placements

Collaborating Clinics	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	
Berkeley Primary Care	5	6	4	6	5	2	2	
West Berkeley Family Practice				1	1	1	1	
East Oakland Clinic				1	1	1	0	
Downtown Oakland Clinic					0	1	1	
Tri-City Health Center					2	2	2	
Glide Health Services						1	2	
Women's Community Clinic							1	
Richmond Health Services							3	
Post Doctoral Student Fellows	2	2	2	2	4	2	1	
# of Students per year	7	8	6	10	13	10	12	
Total # of program completers 2004-05 to 2009-10							54	

Program Design

Trainees are able to develop practical experiences and expected to provide services to patients on a broad range of psycho-behavioral issues not limited to: mental health, treatment compliance, substance abuse, and lifestyle-related disorders such as obesity and smoking. In addition to practical application, *IHPTP* trainees are exposed to a comprehensive curriculum through the term of the program that provides theoretical and practical tools to

prepare them for their work. Students receive training on topics such as: brief screening assessments/inventories; cognitive behavioral and psychodynamic treatments; clinic life skills trainings on topics ranging from how to read a medical chart and write medical notes; how to work within an interdisciplinary team; and how to provide effective and prompt behavioral consults. Students also receive site-specific orientation. Each clinic has its own culture, community context and population demographics, as such each IHPTP trainee receives a unique opportunity to develop culturally competent clinical skills.

Although there are different expectations and levels of engagement in each site, IHPTP has identified the following list of core components and expectations that apply to all aspiring practitioners:

- IHPTP trainees are present in the medical clinics for a predetermined amount of days per week working side-by-side with assigned medical providers.
- IHPTP trainees meet with the IHPTP staff members (supervisors) for weekly supervision, participate in a weekly clinic onsite psychosocial meeting, and provide individual and group psychotherapy services.
- Group psychotherapy intervention programs staffed by students integrate cognitive behavioral techniques, relaxation, and psycho-education components.
- IHPTP trainees are assigned patients through direct referrals from providers.
- Potential participants are assessed for appropriateness for group using a semi-structured interview format conducted by students and sometimes supplemented with standardized screening instruments
- IHPTP trainees utilize standardized assessment screens that include the DASS-22, Beck Depression Inventory-II, the Beck Anxiety Inventory, the Work and Social Adjustment Scale, and the Satisfaction with Life Scales.
- Documentation of patient contacts and assessments are recorded, in the form of medical chart SOAP notes, screening forms, and the agencies' computer tracking systems.

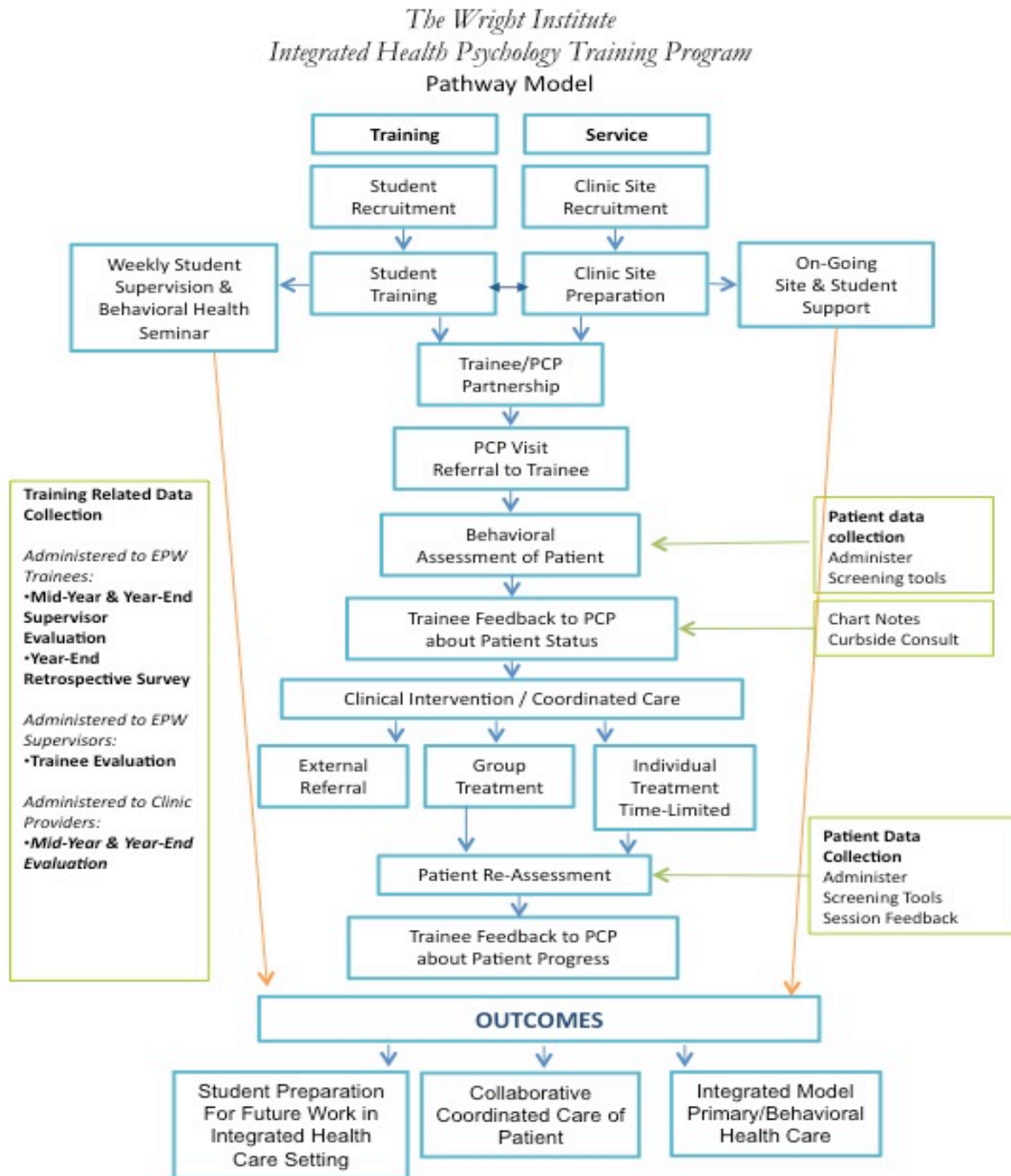
Again, IHPTP trainees' experiences are heavily dependent upon the unique organizational characteristics and practices. As a result, students are matched with an official site contact person (often a staff social worker) whose responsibilities entail helping the student(s) transition into the organization through orientation, mentorship, and by linking them with other providers. Through these linkages, students are able to display their professional expertise and while learning about and engaging in work with other interdisciplinary health professionals. Medical Providers are expected to request the services of trainees through behavioral health consultation, referrals, and warm hand offs by medical staff. Opportunities for peer learning also exist through attendance at formal clinic meetings, while being present in the exam room area, and through self-initiated interactions.

Throughout the year, students are monitored in several ways: 1) onsite weekly meeting 2) sometimes site contact's review of progress notes and charting summaries; 3) participation in weekly IHPTP clinical supervision and review of weekly logs; 4) onsite contacts (medical providers and social workers) and IHPTP supervisors complete a midyear trainee evaluation; and 5) a year-end trainee evaluation. Throughout the year, individual students are able to receive feedback that is focused on developing a competent multidisciplinary trained practitioner.

Partnering sites also obtain feedback and support from the IHPTP liaison -coordinator through site visits, phone calls, and emails and informal discussions with trainees. Formal evaluative feedback are compiled

during various times in the year based on responses obtained through students' weekly clinical supervision meetings; during the clinic's midyear/end of year evaluation; and after the trainees' completion of the supervisor evaluation.

Pathway Model



EVALUATION FINDINGS

Outcome: Impact on Health Consumers

Evaluation questions addressed:

- To what extent are there improvements in consumer general health?
- To what extent is there a decrease in psychological and health symptoms among CHC consumers?

Benefits Experienced by Health Consumers

Benefits experienced by health consumers and physicians relate to trainees' knowledge of various health issues and expertise in exploring behavioral health linkages to presenting problems. Recognizing the integrated clinical setting in which trainees are working, partners suggest that direct links to patient health improvements result from a behavioral health team rather than the work of an individual trainee; however, stories of patient "breakthroughs" suggest clinic partners observed IHPTP trainees positively impacting a patient's well being.

Clinic partners note that the IHPTP trainees' skills and availability provides opportunities for patients to receive traditional psychotherapeutics options such as individual brief therapy that contributes to major impacts in patient health outcomes that might otherwise be unattainable. Furthermore, these patients are described as traumatized and highly inconsistent when engaging in long-term treatments, so the brief therapeutic model was well received and aligned with clinic context. Through these time-sensitive engagements, partners report that trainees were able to build rapport with less trusting patients and provide more extended therapeutic options generally not available to patients with limited economic resources. One-provider states:

She was very, very helpful because there's so few psychotherapeutic options for our patients who either have Medi-Cal or no insurance...She provided consistent therapy for many of our often most difficult patients. People that she could see every week and have the time and the space to do it.

Clinic partners also commented on how impressed they were with the commitment displayed by trainees, particularly in their desire to engage with patients in a respectful manner and provide quality care despite economic circumstances. Partners shared positive remarks about the benefits of having a person available to deliver psychological and behavioral health services to uninsured and underserved patients. Trainees were able to assist individuals experiencing a wide array of environmental stressors. While some of the patients had long experienced challenges in access to health care, trainees were also able to provide inexpensive therapeutic services to a subset of individuals who were most recently affected by the economic downturn and thus new to the challenges of the MediCal health care system.

There's a group of patients that have been struggling in poverty for a long time, and then there's this kind of newer wave of folks who are affected by the recession, those that have worked for 20 years and have recently lost their job and being forced to use public resources.

The opportunity for patients to build a consistent therapeutic relationship was also an added value noted by interviewed providers.

We've gotten mostly really positive feedback from the clients. A lot of them have followed up with me, which shows that they built a really solid foundation and a good trust...they were willing to come and see a stranger because they had such a great experience with an [IHPTP] intern.

Clinic partners varied in their opinions on the utility of including group facilitation as part of the student's activities at the clinic, with some noting that attendance at groups often varies and the IHPTP trainees already have limited time at the site. However, at least one clinic partner noted that in a group utilizing a curriculum developed by a student's supervisor was quite effective:

The student had a supervisor from Wright who developed a curriculum and helped her establish a group. People who came [to the group] gave positive feedback. They felt it was helpful and strengthened their coping skills. We had nurse practitioner co-facilitate the group with the student, so it was billable. It was a win-win where we had this amazing curriculum that the student was enhancing. Having the curriculum support from Wright really made a big difference, versus a student having to use admin time to create curriculum, which is not cost of time effective.

Several clinic partners believed trainees were most impactful when they held experience providing case management services in addition to therapy. In these cases, patients were pleased to have a professional that helped them identify tangible resources that eventually decreased somatic symptoms intensified because of reported deficiencies in basic housing, food, and employment. Trainees who provided traditional psychological services were perceived as less effective in providing responsive services to patients.

The presence of trainees in collaborating clinics also provided an economic relief too many low-income patients who experienced barriers to accessing care and treatment. The integrated health model provided a monetary benefit to patients because they were able to visit their primary care providers and behavioral health provider in one visit without the hassle of additional co-pays and the financial burden of traveling to other locations. The proximity of health related resources were linked to increased treatment compliance.

In general, providers believed the presence of a behavioral health specialist afforded patients the opportunity to explore links to somatic complaints and environmental stressors in a safe space. IHPTP trainees provided time-sensitive therapeutic treatment that was superior to other health options available.

Suggestions for Improving Impact for Health Consumers

Clinic partners offered some suggestions for improvement and insights into factors that increase impact on health consumers. Illustrative quotes from clinic partners are provided for each suggestion.

- Trainees should have prior professional experiences and/or a desire to work with the populations being served by community clinics.

The trainee who just finished up here was very enthusiastic and very competent, and jumped right in and seemed to be motivated to work with our particular patient population. It was a lot easier to involve this student in what was going on than the trainee I had the previous year who, I think, was not particularly interested in working with our particular patient population.

- Knowledge of community health resources will enhance treatment planning: Trainees should be aware aspects of case management duties may be a part of their responsibilities while working in a behavioral health team, and what other members of the team contribute.

As we went along, we kind of had to tell [the IHPTP trainee] to build up his knowledge base about certain things like the roles of different providers that provide therapy services; for instance, a licensed clinical social worker.

Understanding that in some ways there's a cultural consideration in terms of working with low income, multi-cultural, multi-ethnic population, and that it's not about you're less valued because you're doing case management and not psychology or, you know, therapy. But that this is actually - what's most important in this person's life right now, and this opens doors, and this is essential for the person to actually work on some of things that may be from a therapists point of view is - you know, what your goal is.

- Similarly, Trainees should always consider bio-psychosocial influences to presenting problems and be responsive and receptive to prioritizing those factors in treatment

The students need to have an understanding of the psycho-emotional-cultural-social challenges in[underserved] populations, and what the barriers are to accessing healthcare.

Well it's interesting because one of the clients, who was severely mentally ill, had a great relationship [with the IHPTP trainee]. But he didn't get any really social service response until he came to me; and that's significant, you know... I guess she just didn't know. It didn't occur to her, you know, that she should be looking at that piece of it. So she was doing a great job, but those were important pieces

- Trainees' ability to establish rapport and develop partnerships is very influential in building trust and promoting treatment compliance.

Patients, I think, really felt safe with them and comfortable. Those were two comments I've heard a lot, too; just, "I felt safe," and, "I felt listened to." I feel like just using their own self, you know, not even anything that they probably learned in school. They already, you know, were bringing quite a bit to the room.

- Due to the time constraints of a practicum placement, clinic partners reported challenges in establishing groups; however, trainees with support from supervisors in establishing groups and using a developed curriculum can be quite effective and beneficial.

The student had a supervisor from Wright who developed a curriculum and helped her establish a group. People who came [to the group] gave positive feedback. They felt it was helpful and strengthened their coping skills. We had nurse practitioner co-facilitate the group with the student, so it was billable. It was a win-win where we had this amazing curriculum that the student was enhancing. Having the curriculum support from Wright really made a big difference, versus a student having to use admin time to create curriculum, which is not cost of time effective.

Outcome: Student Impact

Evaluation questions addressed:

- To what extent are trainings effective in increasing trainee knowledge of etiology, prevention, diagnosis and treatment of physical and mental illness?
- To what extent is supervision adequate for psychological intervention?

Training and Support

Throughout their 9-month placement, IHPTP trainees received extensive weekly trainings and tools to enhance their mastery of various skills and competencies. Based on program objectives IHPTP trainees were expected to display the following characteristics upon completion of the program:

- Work in a multidisciplinary setting / medical /community health setting
- Work with traumatized/complex low SES populations
- Identify and address the needs of patients who present on a continuum: from acute need all the way to prevention
- Rapid problem identification through behavioral health consults “clinical encounters”
- Assessment skills: being able to correctly identify problem, ask relative questions that provide a more comprehensive understanding of problem.
- Able to administer brief assessments
- Ability to make a differential diagnosis
- Ability to apply appropriate intervention to identified problem.
- Ability to prioritize treatments interventions based on prioritizing multiple problems list.
- Ability to provide time limited interventions that focus on behavioral aspects of patients presenting problems.
- Understand the relationship of medical and psychological systems (mind/body connection) biopsychosocial model of treatment
- Basic understanding of psychotropic medications (such as anxiety, antidepressants, antipsychotics)
- Seeking out appropriate resources and referrals
- Effectiveness and comfort of consulting with medical providers
- Write clear concise medical chart notes & read medical chart.
- Participate in case presentations: for both: brief consultation model to medical providers to longer format for supervisors and colleagues
- Ability to accept feedback from supervisors.

In addition to weekly program-sponsored trainings, IHPTP trainees also received clinical supervision and were able to attend clinic activities sponsored by their placement sites.

Strength of the IHPTP Training Model

2009-2010 IHPTP trainees were asked to rate the training topics that were most relevant/beneficial in their clinic work. Topics relating to stress, depression, PTSD, substance abuse, and diabetes were most frequently indicated. Trainees most valued the opportunity to discuss challenges and problem solve with a supervisor. While, information specifically related to how to work in an interdisciplinary setting yielded less satisfactory ratings. (See Figure 3)

IHPTP trainees’ ratings find some resonance with clinic partners’ reports of trainees’ professionalism and comfort in the beginning of their practicum. Some trainees experienced a short “ramp up time” and readily displayed poise in their ability to communicate their expertise while working with clinic partners; while at least one partner noted that their most recent trainee was anxious throughout most of the practicum experience and attributed it to the student’s general level of preparation and confidence in giving a professional opinion in the setting.

Social workers expressed some concern around the trainees’ knowledge of the roles of different medical professionals, specifically in relation to the apparent distinction between traditional psychological and social work. They offered suggestions that trainees should be aware of the similarities in their roles and thus view them as partners to be engaged in treatment planning. Social workers also suggested that trainees maintain flexibility in treatment planning, overall.

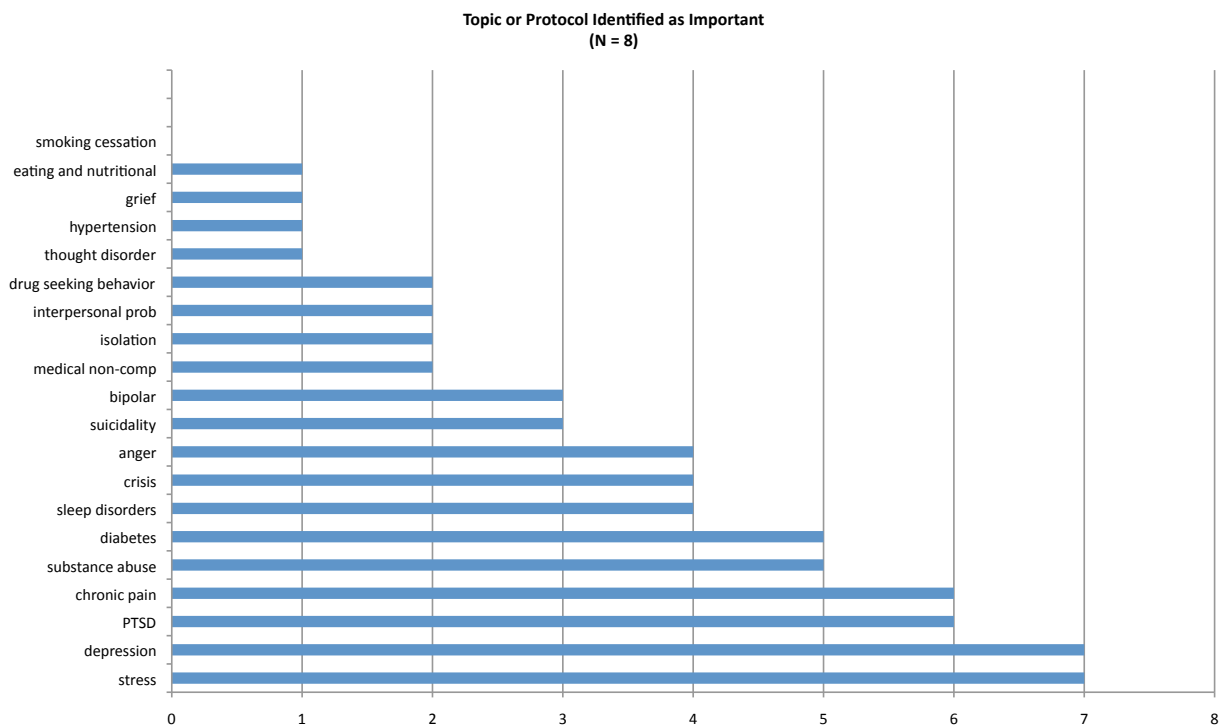
Figure 3: 2009-2010 Trainee Ratings for IHPTP Training and Support

Looking back at the training and support you received during IHPTP, please rate the extent to which training and/or support for the following met your information and learning needs.					
Training related to:	Not Present, Not Needed	Inadequate Trn’g or Support	Adequate Trn’g or Support	Strong Trn’g or Support	Mean
Various interventions/ treatments/ protocols being used with clients	0	0	3	5	3.63
Administering "14 problem screenings & inventories" to patients and understanding results of screens	0	0	3	5	3.63
Working with traumatized, low-income, complex populations	0	2	1	5	3.38
Establishing your role in the primary clinic in which you served	0	1	6	1	3.00
Working in an integrated health setting	0	2	4	2	3.00
Working with ethnically diverse populations	0	4	1	3	2.88
Working in a collaborative, interdisciplinary setting	1	2	3	2	2.75

Figure 4: 2009-2010 Trainee Ratings for IHPTP Opportunities

Looking back at the training and support you received during IHPTP, please rate the extent to which the following OPPORTUNITIES met your information and learning needs.					
Opportunities to:	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
discuss challenges and problem solve with supervisors	0	0	2	6	3.75
work with traumatized, low-income, complex populations	0	1	1	6	3.63
discuss challenges and problem solve with peers	0	0	4	4	3.50
work with ethnically diverse populations	0	2	2	4	3.25

Figure 5: Most Beneficial/Relevant Training Topics Reported by 2009-2010 IHPTP Trainees



In general, IHPTP trainees reported that the training and support provided by Wright IHPTP Clinical Liaison and supervisors prepared them to engage in their practicum experience in a confident manner. Clinic partners who have worked with Wright IHPTP trainees noted that the level of preparation and “fit” has increased over

the years. In one partner’s reflection of her collaborative engagement with the Wright Institute, she noted that the number of trainees assigned to a specific clinic has decreased which has allowed onsite supervisors more time to observe each student and assist them with any challenges. Social workers also commented on the fact that IHPTP has implemented an clinic-student interview process that has been well received by all of the collaborative partners as part of better ensuring trainee ‘fit’ at each site. The initial interactions during these interviews are noted for allowing an opportunity to provide input as to which trainees held skills and attitudes that were in sync with their organizational culture and has increased the site’s sense of responsibility in helping trainees adapt to the environment and new expectations.

Clinic partners expressed appreciation for IHPTP trainees’ skills in using assessment tools to monitor these presenting issues. However, IHPTP trainees reported that they were less clear in how to use the assessment tools in treatment planning. IHPTP trainees also noted the existence of more relevant site-specific assessment tools being used at their respective clinics. Chart notes and treatment planning with clinic partners were also identified as areas in need of improvement. These findings suggest the need for further consideration of what are the most appropriate tools IHPTP trainees need to be trained to use in medical care settings and training that further explores how assessment extends into treatment planning in primary care and how this can be done in collaboration with clinic partners.

In our examination of the IHPTP program’s impact over time reports show that skills learned are transferable and important in student’s careers. A sub-sample of former IHPTP trainees from 2004 to 2009 reported that the core competencies learned in the IHPTP were very important to their current work environments. Some of the highest rated competencies developed were the ability to work with multidisciplinary partners and to identify problems quickly. The figures (Figures 6-9) below provide a summary of how former IHPTP trainees rated the importance of IHPTP core competencies and how they have contributed to their current education and/or work.

Figure 6. 2004-05 through 2008-09 Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies I

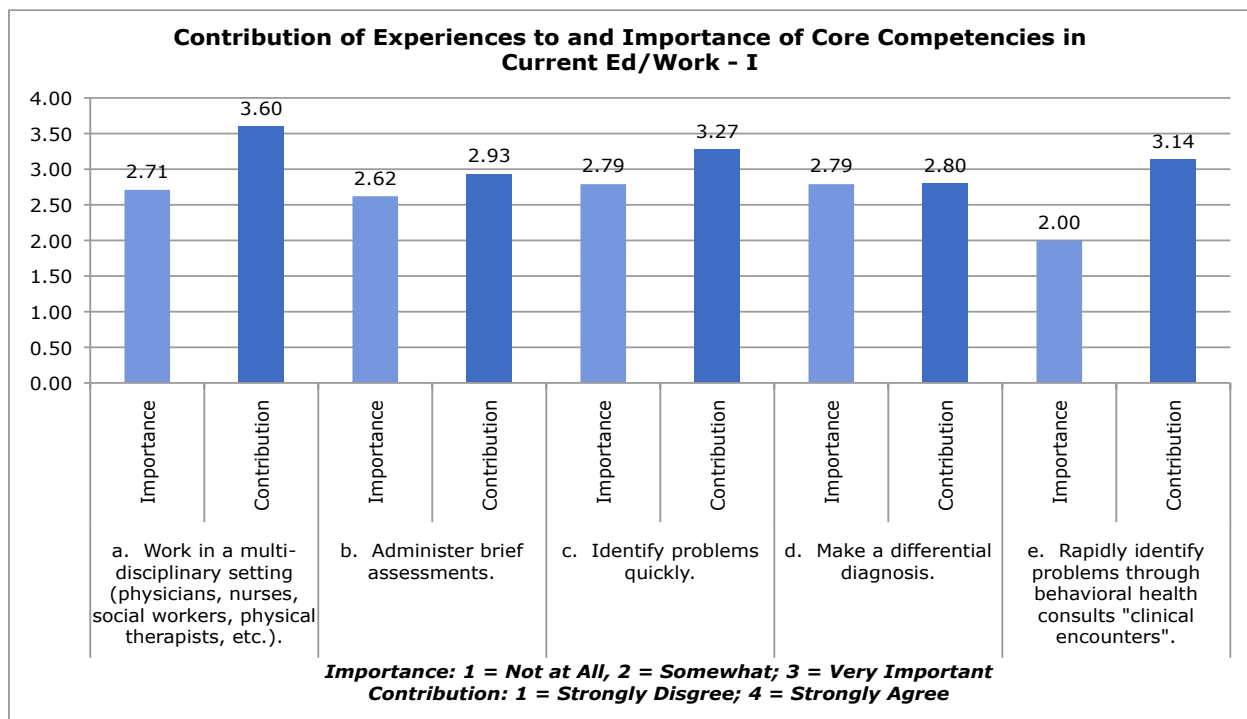


Figure 7. 2004-05 through 2008-09 Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies II

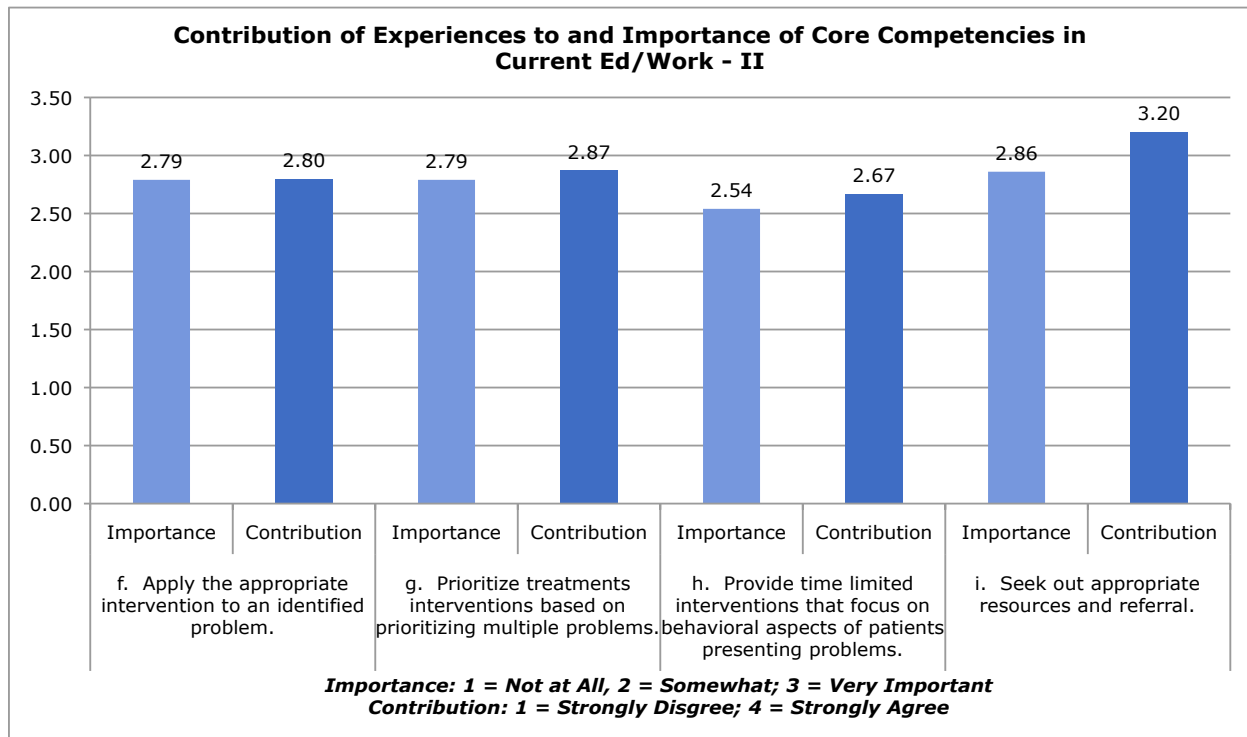


Figure 8. 2004-05 through 2008-09 Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies III

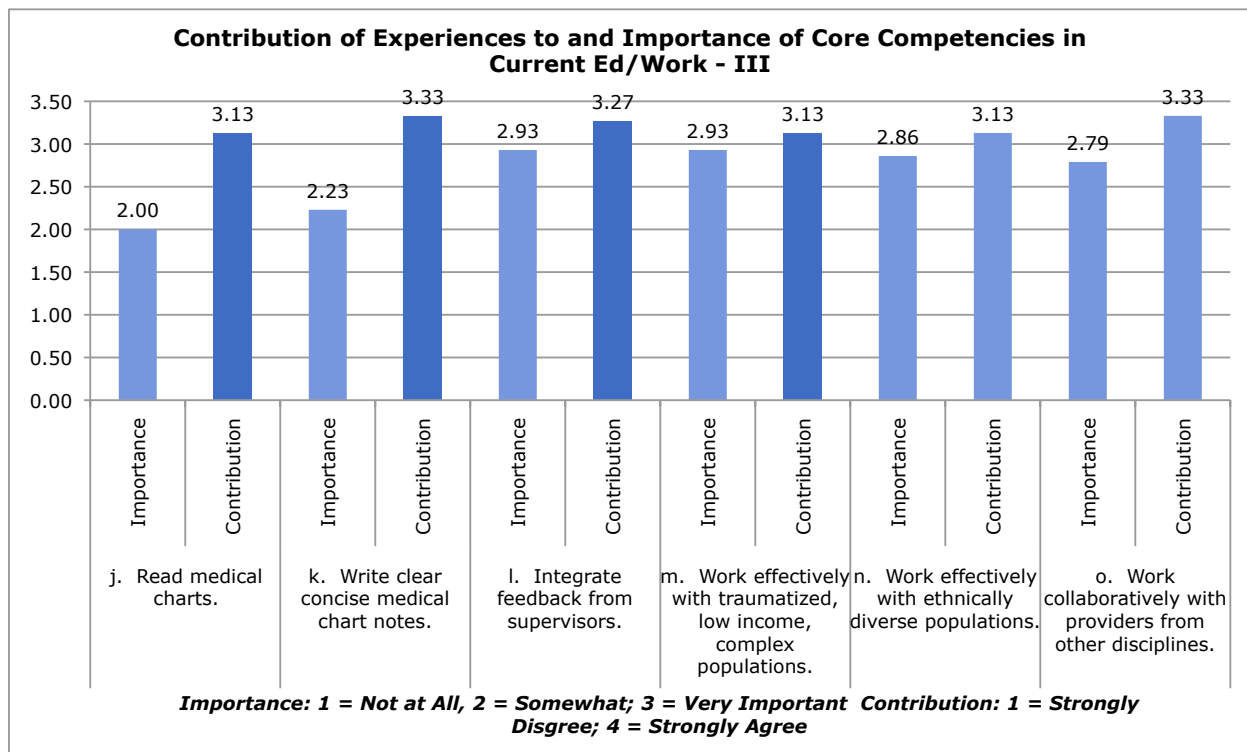
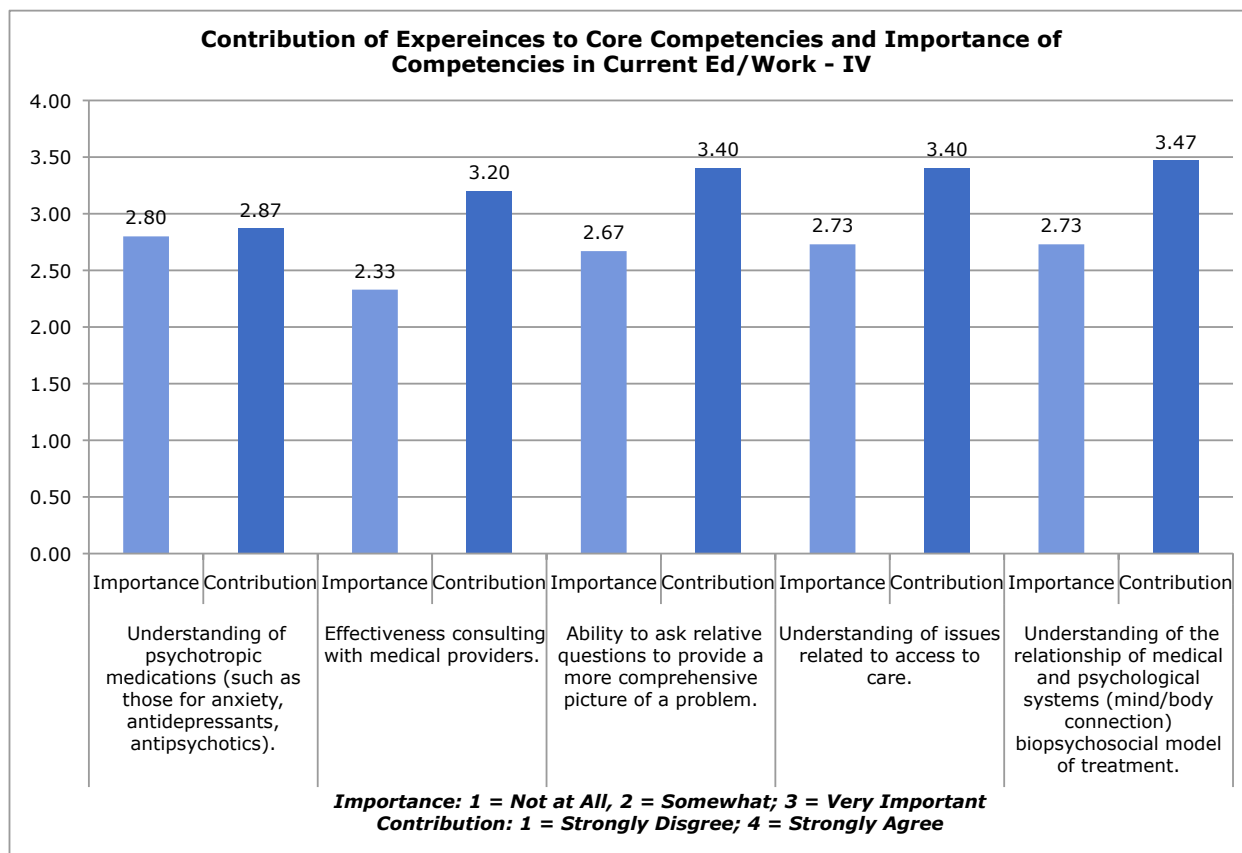


Figure 9. 2004-05 through 2008-09 Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies IV



Training and Support Related to Cultural Competence

The IHPTP training program is geared toward developing clinicians that can provide services to patients' who are experiencing economic, educational, and cultural barriers in obtaining access to medical treatment, thus respondents continually noted the importance of trainees being able to respond to a range of individual circumstances that may be displayed throughout their interactions with patients. And, the need for cultural competence was a common theme across IHPTP trainees and clinic partners.

Interestingly, there were some differences related to training to work with diverse individuals. 2009-10 IHPTP trainees rated the training to work with traumatized, low-income, complex patient populations adequate to strong, but were less satisfied with training more specific to working with ethnically diverse populations. Additionally, clinic partners recognized some areas for improvement, noting that students need to be able to translate professional jargon into language that understandable to the patients and that their clinics serves clients with a broad range of primary languages and English language fluency.

A lot of our patients are from Southeast Asia, the Middle East; we also have a lot of Spanish-speaking, monolingual Spanish speakers, and Farsi speakers.

Students are expected to have an understanding of the psycho-emotional-cultural-social challenges faced by their clients or at minimum be able to conceptualize potential barriers that might impede treatment

compliance. Clinic partners found that trainees with related professional or volunteer experiences were less intimidated by the experience and able to provide services that are more responsive to the needs of the individual; they also recognized that this breadth of knowledge is not one obtained through participation in one clinical experience. Rather it was important to be aware of and honest about one's ignorance in these areas, view these experiences as a chance to learn from the patient and seek out additional support from clinic partners and other resources.

They have to have cross-cultural sense...You don't have to know X, Y, and Z, but you have to be quietly aware that it's - that difference is present and you need to be curious about that.

Training and Support Related to Clinic Organizational Culture

Each practicum placement site had its own organizational culture that influenced trainee's ability to implement tools and clinical advice offered through IHPTP training and through supervision. The current program model requires that the IHPTP Clinical Liaison visit each site placement at mutually agreed upon intervals throughout the 9-month practicum term.

Clinic partners found value in the external check-ins, and viewed these visits as opportunities to vocalize their needs and respond to students shared through feedback received from the Liaison. Site visits also allowed program administrators the opportunity to observe site characteristics that affect a student's ability to navigate their training experience. All respondents believed site visits were influential in managing IHPTP trainees and placement site expectation and suggest continue with at least the same frequency and are scheduled as early as possible after the practicum begins.

Clinic partners suggested that site visits should include the IHPTP trainees' offsite clinical supervisors. It was their belief that clinical supervisors participation would provide a constructive opportunity to observe the organizational practices of each placement site. Clinical administrators felt that IHPTP trainees were often expected to complete program requirements or implement clinical advice that lacked insight into the organizational culture or client needs. As one respondent shares:

The student we had last year was excellent, very great clinician but kept putting an urgent housing need on the backburner in order to provide intervention; and her Wright supervisor was insisting she do. And so this was a patient who was anxious about her housing and was treated for anxiety.

Consistent and structured site visits would ultimately allow supervisors the opportunity to observe vital organizational characteristics related to: space restrictions; size of the organization, number of other trainees (nurse, interns, AmeriCorps etc); presence of a predominate training model, or other contextual considerations that promote or inhibit trainees success.

Suggestions for Improving Training and Support

Overall IHPTP trainees and partners believed that the experiences by participation in the IHPTP program provided them with the technical skills and practical experiences and confidence to work with diverse populations and interdisciplinary partners. Former IHPTP trainees have shown that these skills have been influential across most of their professional and scholastic endeavors. General suggestions for the enhancement of training and preparation for both parties are as follows:

- There should be more communication around **start dates** and IHPTP trainees should start practicum engagements as early as possible.

- Training should include ways to increase **verbal and written communication skills that are appropriate for the patients** with various literacy levels and medical providers who may vary in their behavioral health backgrounds.
- **Offsite clinical supervisors should be required to complete initial site visits** and should have practical knowledge of and considerations for working in a community health setting and provide relevant clinical advice during supervision.
- IHPTP trainees should be exposed to the **most relevant tools needed in a primary care** setting such as how to read a medical chart or how to do a SOAP note, administration of health-related inventories.
- **Cultural competency training** should include practical recommendations for treatment adaptations.
- Provide guidelines for trainees as to how to **integrate other assessment tools** used at the placement sites.
- Training should **prepare IHPTP trainees to educate clinic partners on their role** as behavioral health specialists.
- The IHPTP program should include **more opportunities for cohort members and former IHPTP trainees to provide support** to each other.

OUTCOME: INTERGRATION & COLLABORATION

Evaluation questions addressed:

- In what ways are trainees and other health service providers collaborating on client care?
- To what extent are these collaborations increasing and/or improving?
- To what extent are trainees providing mental health services in CHC centers?
- In what ways does IHPTP add value to the clinics?

Collaborating on client care

Trainees experience opportunities to work within an interdisciplinary team at variable rates during the placement term. Trainees are asked to collaborate with other health professions during three types of consultations: medical, individual, and group. Based on logs submitted by the 2009-10 IHPTP Trainees, trainees are most frequently engaged in individual treatment during the length of their practicum training (see Figure 10).

IHPTP trainees were asked to provide expertise primarily on mental health issues such as: Depression; Anxiety; PTSD; Emotion Regulation; Coping; Mindfulness-Based Stress Reduction; Self-Esteem. Other common consultations included topics ranging from Substance Abuse, Better Quality of Life, to Sobriety and Smoking Cessation.

Figure 10: Clinical Consultation Frequency & Type

Frequency of Consults to Date	Medical Consults (N = 8)	Individual Consults (N = 8)	Group Consults (N = 6)
Total Number of Consults	188	508	43
Average # Per Student	24	64	7
Average # Per Student Per Week	2	4	2
Average Length of Consults	32 minutes	58 minutes	120 minutes
Min/Max Length of Consults (minutes)	min=3 max=180	min=10 max=180	min=60 max=270

Factors facilitating integrated model with IHPTP Trainees

According to reports made in conversations with clinic partners, the overall extent to which trainees were engaged in and able to develop collaborative partnerships are influenced by the following factors:

Presence of a clinical champion: Clinic partners with prior experience managing a trainee program confirmed the importance of identifying one or two providers to act as mentors to the trainees. These champions usually act as facilitators, promoting the trainees competencies and patient benefits to other colleagues and creating opportunities to make use of trainees as additional resources.

Paradigm Shifts: There are apparent challenges involved with developing relationships with providers who do not find value in an interdisciplinary model. One provider shared, "I still have the sense that in many of the other sites there's still a disconnect between primary care and mental health, and that's a conversation bigger than the Wright [Institute's program]." When promoting the use of trainees, providers described instances of individual reluctance to expose new practitioners to patients and shared these barriers with the Clinical Liaison. As one noted:

I think there are some providers who have a view that somehow bringing a student in is doing the student the favor and weighing down their time, and it's kind of an onerous burden. We are still working on this - how to shift the view to so the providers can see what these students are able to do and altering their views to believe, "Here's another asset, this is what they can do."

In response to this feedback, IHPTP has worked to address concerns through presentations to medical providers. These presentations focus on describing the skills of the trainee and providing practical examples about ways in which their skills can benefit their work with patients. Clinic partners noted that these types of peer education presentations exercises were important and should continue.

Site characteristics: Larger site placements provided more orientation and structure around managing new trainees but also held more opportunities for them to feel disconnected from other professionals. IHPTP trainees at these sites encountered separations between behavioral health and primary care services that decreased their opportunities to maintain visibility and use of their primary care consultation skills as a priority for other medical providers. Smaller sites with shared office space provided more ideal environments in which IHPTP trainees were able to build relationships that lead to increased confidence in the use of their skills.

Additional factors that were thought to facilitate the effectiveness of an interdisciplinary model are highlighted in the points below.

- **Consistent practicum start dates** would allow sites more time to begin conversations with potential clinic champions or identify mentors
- **IHPTP trainees should be prepared to exhibit an assertive yet inquisitive attitude** when working with clinic partners. Trainees need to be able earn the trust of the providers who are skeptical yet open to collaborating with those professionals that they perceive to be competent. As explained by one clinic partner who within their own role has experienced the challenges of an interdisciplinary approach:

I think there is disconnect for the primary care providers. If they don't really see somebody frequently, and they're in the middle of their hustle and bustle in their busy schedule, they could very well forget that there's a resource available for them because it's something new for us to have that service in the clinic. We're trying to do a lot of promotion. I think, slowly, it's coming along, and they're feeling more comfortable calling us for consults. There are a lot of doctors that kind of keep to themselves, or don't eat with us, so you just never see them. They come in and see their patients and leave. Therefore, we have tried to incorporate presentations at in-services, which has been helpful. We speak at provider meetings, and offer our services, and remind them, you know, that we're here to help them.

- Student schedules need to consider/include explicit guidelines around the **student's availability to attend organizational meetings**. For instance, a trainee that can participate in onsite clinic staff meetings is better able to have opportunities to demonstrate their competence to a larger group of providers and become integrated into the staff.

Ongoing Promotion of Integrated Model – IHPTP Trainee Career Paths

Almost all (88%) of the eight 2009-2010 IHPTP trainees reported that they were much more likely to pursue a career in an integrated health setting due the experiences they encountered as a student within IHPTP. One 2009-10 trainee shares:

It was very quickly apparent how much greater of a difference I could make in an integrated health setting rather than in "private clinic" settings. It was very fulfilling to see how our work didn't just help people cope with depression or anxiety, but in addition, could help prolong life and quality. I also felt that my profession was a crucial part of the patient's recovery. I know I can look forward to continuing in this direction.

Former IHPTP trainees of the training program shared similar sentiments. While nearly all respondents are continuing towards their doctoral degrees, a few respondents (17%) indicate that they are currently working in an integrated health setting with each indicating that their experiences in IHPTP contributed somewhat or greatly to their decision to work in this setting. And among those not currently working in an integrated setting, the majority (75%) indicated that they are somewhat or much more likely to be involved in an integrated health setting because of their experiences in BPC/IHPTP. As one program completer noted:

I felt useful within the primary care setting--I kept sensing the overwhelming need for psychology's ability to reach the underserved in these settings. I feel there is such a disconnect in our culture from our bodies and our internal experience, and witnessing, first hand, how these factors are interrelated while working in a primary care setting has led me to pursue continued work within a medical setting.

Added Value of IHPTP for Clinics

In reviewing the focus group and interview data, several items emerged as benefits to clinic partners as result of their participation in IHPTP.

Assessment Tools: Clinic partners found value in the brief assessments administered by Wright trainees. IHPTP trainees expressed similar views, noting that the tools helped them maximize their time with patients.

Opportunities to increase revenue: An interdisciplinary model allows partners the opportunity to take advantage of additional revenue streams that enhance clinic revenue. The opportunity to have a developed group curriculum or individual to work on facilitating group sessions provides an opportunity for expanded billing. An interdisciplinary model also maximizes the quality of engagements experienced between a primary care physician and their patients because they are better able to address treatment noncompliance after consulting with a trainee who has had time to explore potential environmental factors.

Recruitment: Over half of the graduates and former trainees of the IHPTP program indicated that their experiences in collaborating organizations increased the likelihood to pursue a career working with diverse individuals. For that reason, clinics should attempt to use these relationships to recruit individuals who have established a professional expertise and expressed a desire to work in similar settings.

Promotion of scholarship and ability to inspire: Clinic partners expressed a general sense of personal satisfaction throughout interviews when they described their work with trainees and the opportunity to share their passions for helping underserved communities. It was apparent that despite the commitment of personal time, their motivations to work with trainees were driven by their desire to give back and inspire others to follow a similar career path.

The findings from recent data collection efforts are consistent with earlier feedback from clinic partners. As the comment from a partner following the 2006-07 academic year demonstrates:

Having Wright interns has been incredibly valuable to the psychosocial services offered by [our clinic]. While [our clinic] has had to put in some resources to take advantage of their contribution (chiefly by providing counseling space and an hour of time from the psychosocial team for a meeting with them), they provide services that complement and enhance the mission of [our clinic]. The chief benefits I've seen from having Wright Interns:

- *The ability of the clinic to offer psychotherapy without co-pay - a service not available in the community - makes therapy available to low- and no-income patients who would otherwise not be able to get it*
- *The energy to get groups going - always a challenge but incredibly valuable clinically. If a culture of groups can get established, groups could potentially develop into a billable vehicle.*
- *Increasing the psychological-mindedness of the clinic, which enhances integration of the bio-psychosocial model. Not only is this true, but it's a nice thing to point out when writing grants.*

SUCCESS OF IHPTP MODEL

Overall, across the last six years the Wright Institute has held many successes in their attempt to promote a comprehensive behavioral health care model by training clinical psychology doctoral level students.

Administrators have successfully trained and introduced IHPTP trainees to the satisfaction gained through by providing behavioral/mental health services to underserved populations in community health care settings. IHPTP trainees who have completed the program are positive in their assessments of its impact on their knowledge and skills as well as its influence on their future career plans.

The program has developed a reputation amongst clinic providers who continue to support the work of the program with student placements each year. These relationships have slowly improved collaborative relationships between interdisciplinary professionals and increased effective treatment planning for health consumers.

Programmatically, modifications based on lessons learned have led the program to strengthen its:

- Placement systems to that match the needs of client sites and experiences of the student;
- Breadth of training topics for IHPTP trainees that has increased trainee competency and confidence when working with clinic partners;
- Preparation of IHPTP trainees to use tools to perform rapid and differential diagnoses;
- Partnerships with collaborating organizations;
- Promotion of the benefits of interdisciplinary model among the field;
- Exposure of students who are engaged in work in high need settings.

ONE IHPTP TRAINEE'S STORY

Working along side medical providers has been a challenging and exciting process. Community health seems to attract dedicated professionals, and I've been honored to be part of such a hard working team.

If there has been any difficulty, it has been in getting the doctors to relinquish the psychosocial and behavioral health piece to me. This is a clinic where patients come in just to visit their doctor, and the doctor makes time to simply sit and catch up. However, over the course of the year, I have been able to demonstrate my utility in improving the quality of life of their patients, so rather than lose that personal rapport, they are now better providing patient care.

An example of this would be an occasion when I was called in to assess a young woman whose roommate had recently disappeared. She was distraught, and the doctor could not stay. So after the three of us spoke about the event, the doctor left the room and I was able to do a more thorough assessment. It was during this conversation that she revealed that she had been taking a serious number of klonopin and that she was steadily drinking as well. I was able to do psychoeducation about the dangers of this behavior, and taught her several relaxation techniques, which seemed to help soothe and calm her. She agreed to come in for a regular appointment, and through this contact we've done a very successful protocol for anxiety and coping, which has supported her through an extremely heart wrenching experience.

Yesterday, there was a note in the file from her primary care doctor, thanking me for assisting her patient and commending my intervention. It's moments like this one that make me so thrilled to be doing the work.

LESSONS LEARNED & RECOMMENDATIONS

The following provides a collection of the lessons learned across all respondents involved in the evaluation of the IHPTP program. This summary is organized to provide an insight gained (*finding*) and concurrent recommendations for programmatic improvement organized in two categories: 1) student training and preparation and 2) Promotion of Integrated Health Psychology Training Model.

Student Training & Preparation

Finding: Clinic partners observed and IHPTP trainees experienced levels of discomfort when engaged in clinical consultations.

Recommendation #1: Provide an overview of potential interdisciplinary partners; add mock consultations to practice communication

Finding: Preparations to utilize assessment tools were useful but sites may have tools that are more medically and/or culturally appropriate for their populations in primary care settings. It is also important for students to review the connection between assessments and treatment planning.

Recommendation #2: Identify or develop more relevant tools that reflect the needs of the population being served and align with those used at the clinics. Provide more explicit directions to trainees to support treatment planning.

Finding: Communication skills should include how to translate professional advice through different mediums and across diverse individuals.

Recommendation #3: Include review of charting and medical chart reading in curriculum and provide exercises to enhance written communication. Training should also include strategies to that increase communication with other professionals and patients with various educational levels.

Promotion of Integrated Health Psychology Training Model

Finding: The general 9-month period in which trainees programs are completed are highly anticipated by clinic providers.

Recommendation #4: Provide clear start dates for IHPTP and guidelines around student schedules that responded to the needs of the sites.

Finding: Direct linkages to show the impact of professional services are difficult to determine within an interdisciplinary model.

Recommendation #5: Consider what existing documentation might best be able to speak to health outcomes and how it could be more systematically compiled and reviewed. Continue to review and consider key data collection tools and data management practices to assess how best to document impacts within an interdisciplinary model.

Finding: Historical linkages to behavioral health and primary care are not apparent in all clinical placements. Some medical providers maintain reluctant attitudes to engage with other professionals around treatment planning.

Recommendation: #6: IHPTP trainees should review self-promotion strategies and ways to educate health professionals on the importance of behavioral health

Finding: Clinic calendars and meeting topics are set months in advance. Plans to promote the program should be scheduled prior to the beginning of a practicum term.

Recommendation: #7: Work with clinic administrators to schedule IHPTP program presentations to coincide with preset clinic wide meeting when possible.

Appendix A
Summaries of Survey Findings

FALL 2004-FALL 2008 PROGRAM COMPLETER SURVEY SUMMARY

OVERVIEW

This document overviews preliminary findings from the Spring 2010 survey of Berkeley Primary Care (BPC) and Integrated Health Psychology Training Program (IHPTP) program completers. At the time of this summary, the survey remains open for responses, and thus findings are subject to change upon completion of data collection and further analysis of these and additional data. Open-ended responses contained in this summary represent a selection of those in the current data set; full analysis and integration of open-ended comments will be conducted upon completion of data collection.

WHO RESPONDED

As of this summary (April 7, 2010) a total of 18 of 32 program completers have responded to the survey for a preliminary response rate of 56%.

Program completers received an initial email from Dr. Gilbert Neumann informing them of the forthcoming survey's purpose and the role of fdcPartnerships in administering the survey on March 19, 2010. This email was followed by the formal request for participation and link to complete the survey sent by fdcPartnerships on March 23, 2010. Reminder emails were sent on March 31, 2010 and April 6, 2010. Additionally, an email with a link to the survey was also sent to the secondary email addresses of all non-respondents on April 1, 2010.

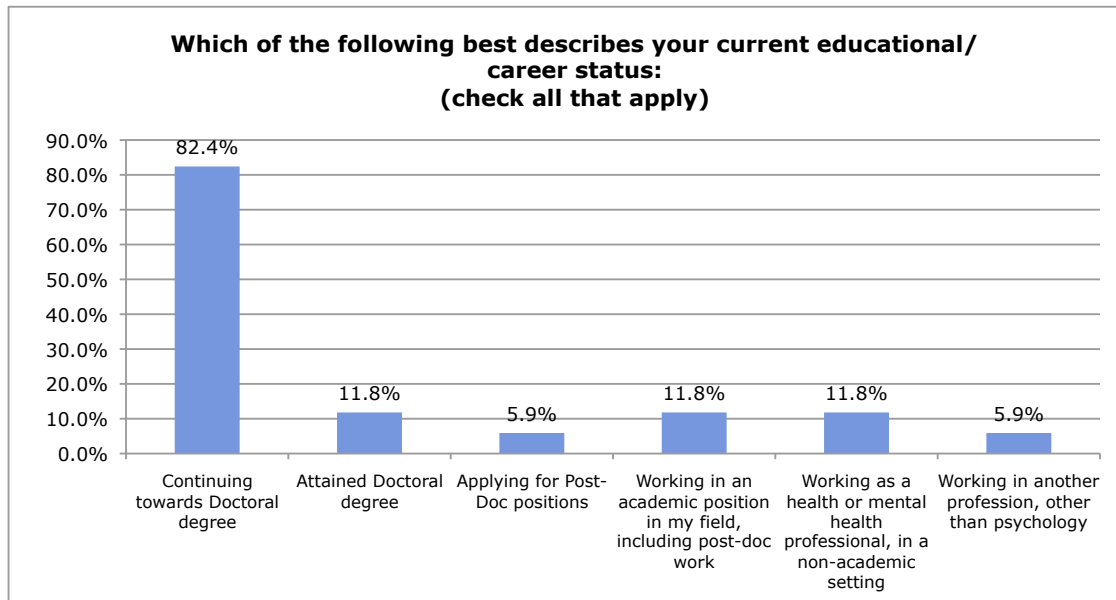
Year of Participation for Respondents

Among these 18 respondents, approximately three-fourths are from the Fall 2007 or Fall 2008 cohorts. Just over one-fifth of respondents are from the Fall 2004 cohort and one respondent is from Fall 2006. To date, no one from the Fall 2005 cohort has responded.

Current Education / Career Status of Respondents

Among these 18 respondents, nearly all (82%) are continuing their doctoral studies. Among those who have attained their doctorate, one is currently in a post-doc position and the other is working as a health or mental health professional in a non-academic setting. Respondents vary in terms of the settings they have been exposed to as part of their employment and/or academic training; however, 63% report that at least some of their work since completing BPC/IHPTP has taken place in medically underserved communities.

Figure 1. Program Completer Current Educational/Career Status



PRELIMINARY SURVEY FINDINGS

Efficacy of Training and Program Experiences

For these respondents, the strongest aspects of the training included opportunities to work with ethnically diverse populations and traumatized, low-income populations (87% rated the training or support adequate or strong). Also highly rated were opportunities to discuss challenges and problem solve with supervisors or peers (82% rated adequate or strong). While program completers ratings for the specific training content areas suggest that there is room for strengthening or refining some of these specific areas to ensure their support for/relevance to the work IHPTP trainees encounter in the clinics in which they serve, program completers indicate that strongest content piece of the training according to these respondents was that specific to the various interventions/treatments/protocols being used with clients (69% rating this adequate or strong).

Contribution of Experiences to Development of Core Competencies and Importance of Core Competencies in Current Ed/Work

In terms of experiences in the program contributing to abilities related to anticipated core competencies, most respondents tended to agree or strongly agree that their experiences contributed to the specific competencies. Overall, most respondents either agree or strongly that their experiences contributed to development of core competencies. On average, respondents most strongly agreed that experiences contributed to their ability to work in a multi-disciplinary setting (mean rating = 3.60 on four-point scale where 1 = strongly disagree and 4 = strongly agree) and work collaboratively with providers from other disciplines. Ratings also reflect that for most participants, the experiences contributed to understanding and/or effectiveness in key areas, most especially to understanding of the relationship the relationship of medical and psychological systems biopsychosocial model of treatment and issues related to access to care, as well as their effectiveness in asking relative questions to provide a more comprehensive picture of a client's problems. Furthermore, on average, respondents indicate that nearly all of these competencies are very important to their current education/work. Further analyses are needed to accurately capture the range and typical nature of experiences among program completers.

The four figures (Figures 2-5) below display the rating of contribution along side importance to current education and/or work.

Figure 2. Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies I

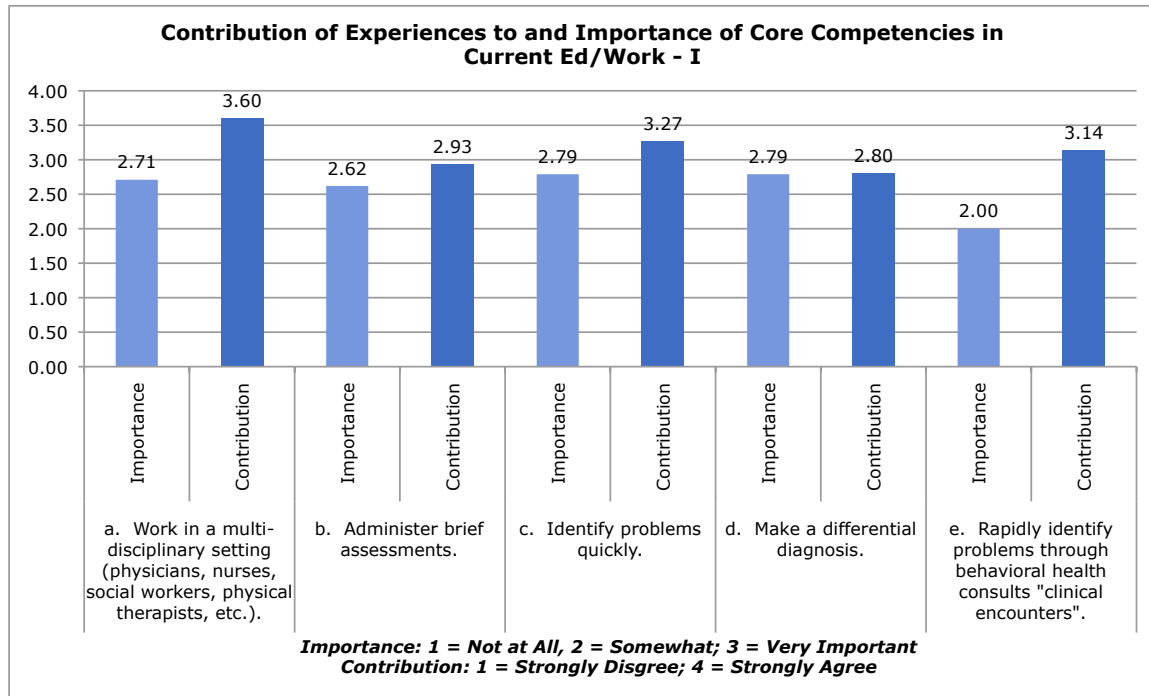


Figure 3. Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies II

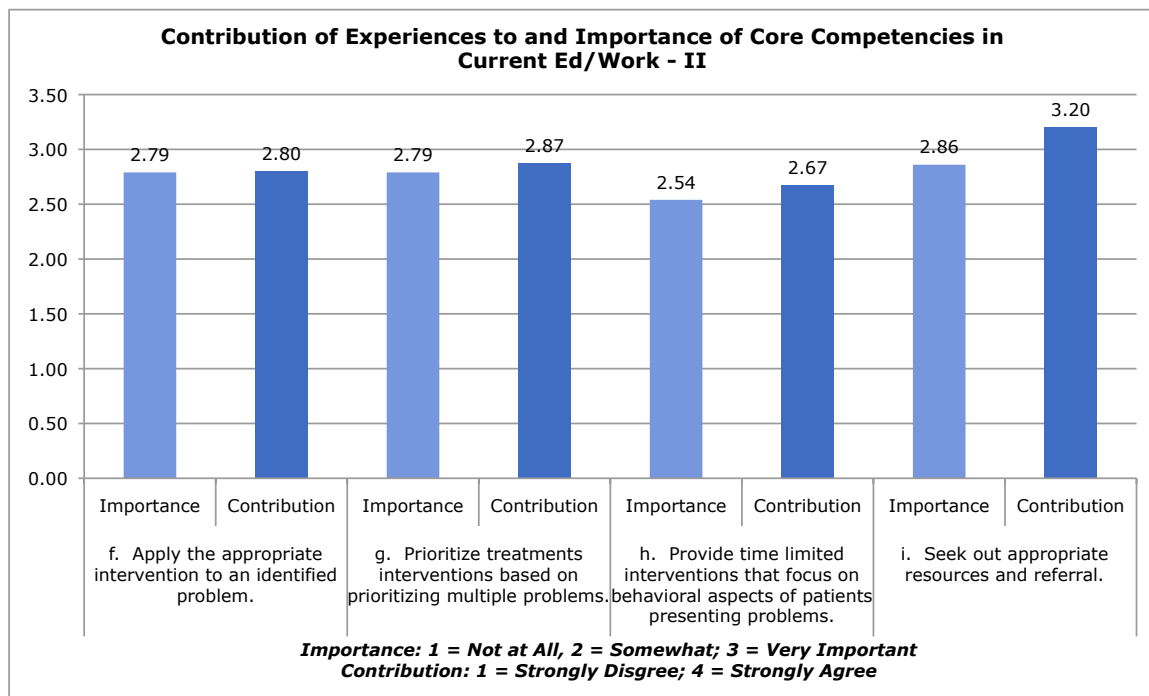


Figure 4. Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies III

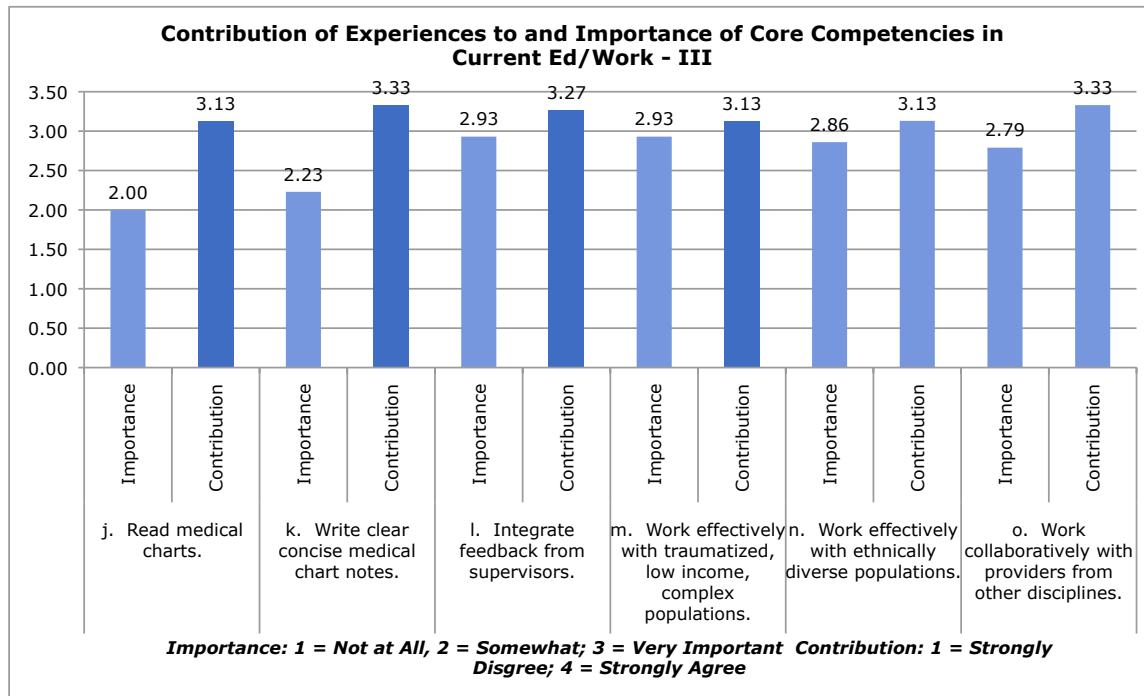
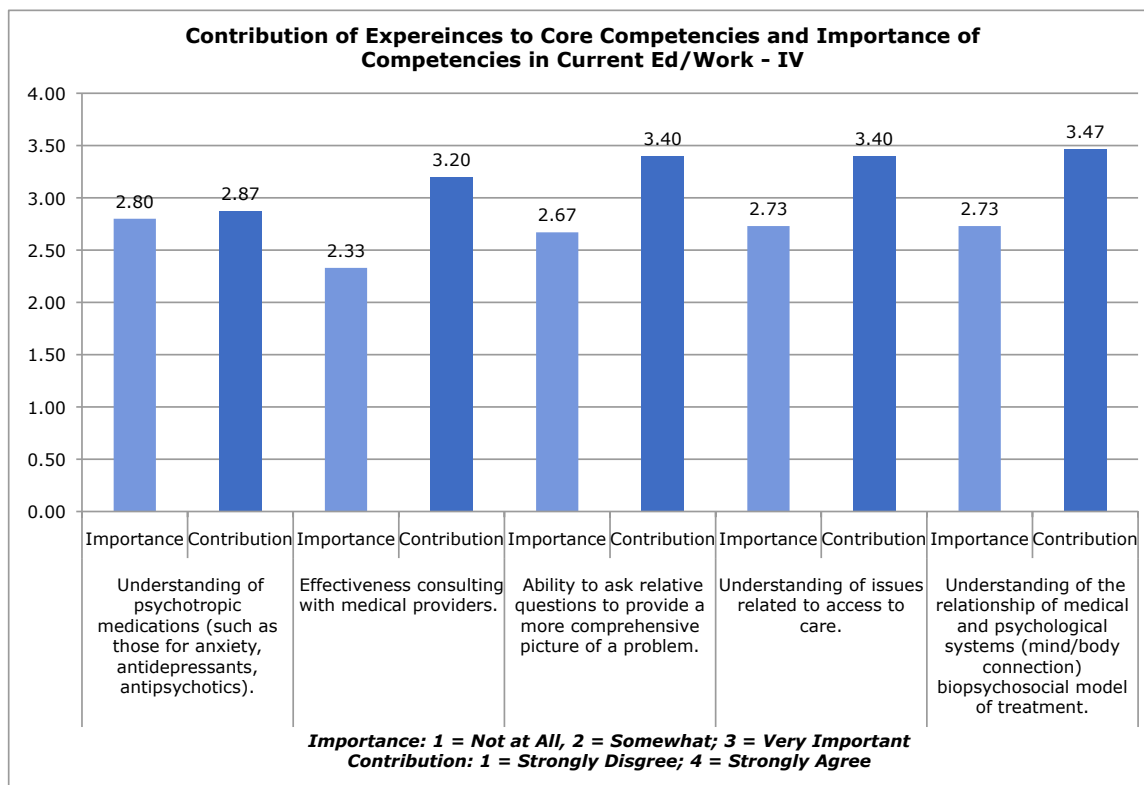


Figure 5. Program Completer Ratings for Contribution of Experiences to/Importance of Core Competencies IV



Continued Work in Integrated Health Settings

While nearly all respondents are continuing towards their doctoral degrees, a few respondents (17%) indicate that they are currently working in an integrated health setting with each indicated that their experiences in BPC/IHPTP contributed somewhat or greatly to their decision to work in this setting. As one respondent noted:

I felt useful within the primary care setting--I kept sensing the overwhelming need for psychology's ability to reach the underserved in these settings. I feel there is such a disconnect in our culture from our bodies and our internal experience, and witnessing, first hand, how these factors are interrelated while working in a primary care setting has led me to pursue continued work within a medical setting.

And among those not currently working in an integrated setting, the majority (75%) indicated that they are somewhat or much more likely to be involved in an integrated health setting because of their experiences in BPC/IHPTP.

RESPONDENT COMMENTS

Highlights from selected open-ended questions are provided in the sections below. Please note, these are selection to provide an overall sense of the nature of respondent comments.

Influence on decision/desire to pursue opportunities in integrated health setting

- I am very interested in pursuing jobs in behavioral medicine, and am currently investigating opportunities for such work on college campuses, Kaisers, and/or VA's.
- I like working in a multidisciplinary team. I am comfortable in medical setting.
- My predoctoral internship will be at a community health clinic, affiliated with a school of medicine, which provides substance abuse, trauma, and interpersonal violence treatment.

Suggestions for Improvement/ How could BPC/IHPTP better prepare IHPTP Trainees

- Better systems in place in regards to practicalities such as scheduling and meeting
- More cultural sensitivity in working with diverse populations and how to interact with doctors or other medical providers who may be lacking in that regard or need more knowledge.
- More work on motivational interviewing and motivational enhancement techniques would be helpful to assist patients to fully collaborate in and engage in both psychological and medical treatments.
- Need strong buy in from the medical counterpart, including physicians, which requires time and a longterm, sustained and consistent effort to build. A postdoc is in my view the wrong person to manage the program on the ground as she/he lacks legitimacy and LT continuity.
- More comprehensive psychopharm training (which should really just be part of the Wright curriculum, as it used to be).
- More support was needed when establishing the behavioral health consultant's role at the clinic.

Greatest benefits

- Nearly six years later, the interactions I had with the largely homeless youth (18-25) patient population stand out as some of my most vital training experiences to date. It was a crash course in rapid assessment, brief intervention, the biopsychosocial model, and managing complex interdisciplinary relationships on a treatment team.
- I enjoyed the opportunity to work with underserved, culturally diverse patients, some of who had never previously received psychological services. Working with a supervisor, who is a practicing psychiatrist, was a very informative and intensive learning experience. I had the opportunity to co-facilitate a chronic pain support group for patients.
- I view my training experience at BPC/IHPTP an excellent foundation for additional training and working in health/primary care psychology. I gained invaluable clinical experience in working with a culturally diverse, underserved patient population and a strong primary care medical team. I have recommended the BPC/IHPTP training practicum to many of my student colleagues. Also the training might also focus more on cognitive-behavioral treatment protocols which have evidence-based research support such protocols are extensively used in the field of health psychology.
- It was my first opportunity to work consistently with individuals for an entire academic year.
- Increasing my knowledge of medical issues and their interactions with psychological ones.
- It gave me great experience working with doctors and nurses, reading medical charts, and working clinically with a very diverse population on health issues.
- Ability to highlight the intersection between mind/body, and how it can play out in the human experience, at least as seen in an underserved setting.
- Learning how to collaborate/consult with other healthcare providers

Area of Questioning: MOST USEFUL TRAININGS

Eight respondents offered information about the most useful trainings they received through the program. The opportunity to discuss challenges and problem solve with a supervisor received the highest rating (3.75). Trainings on various interventions, treatments, and protocols being used with clients and administering the "14 problem screenings & inventories to patients and understanding the results of the screens also received high average ratings (both 3.63).

Interestingly, the opportunity to work with traumatized, low income populations received usefulness rating of 3.5 and thus was more beneficial than the actual training which received a usefulness rating of 3.38.

Overall, the participants felt they received more support around facilitating brief sessions (3.5) than they did learning to facilitate therapeutic groups (2.5).

1. Looking back at the training and support you received during IHPTP, please rate the extent to which training and/or support for the following met your information and learning needs.					
Training and Support related to:	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
b. the various interventions/ treatments/ protocols being used with clients	0	0	3	5	3.63
g. administering "14 problem screenings & inventories" to patients and understanding results of screens	0	0	3	5	3.63
e. working with traumatized, low-income, complex populations	0	2	1	5	3.38
a. establishing your role in the primary clinic in which you served	0	1	6	1	3.00
c. working in an integrated health setting	0	2	4	2	3.00
f. working with ethnically diverse populations	0	4	1	3	2.88
d. working in a collaborative, interdisciplinary setting	1	2	3	2	2.75

2. Looking back at the training and support you received during IHPTP, please rate the extent to which the following opportunities met your information and learning needs.					
Opportunities to:	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
b. discuss challenges and problem solve with supervisors	0	0	2	6	3.75
c. work with traumatized, low-income, complex populations	0	1	1	6	3.63
a. discuss challenges and problem solve with peers	0	0	4	4	3.50
d. work with ethnically diverse populations	0	2	2	4	3.25

3. Looking back at the training and support you received during IHPTP, please rate the extent to which the following met your information and learning needs.					
Training and Support related to GROUP FACILITATION	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
a. Training/supervision addressed how to manage brief sessions	0	1	2	5	3.50
b. Training content specific to facilitating therapeutic/psycho-educational groups	1	4	1	2	2.50

Area of Questioning: TOPICS AND ISSUES

Of the eight respondents who answered the question about which topics covered during the Behavioral Health Seminars were the most important to cover, all eight identified emotional dysregulation and anxiety. More than half of the participants identified diabetes, substance abuse, chronic pain, PTSD, depression, stress, and anxiety as important topics as well.

Only seven respondents addressed the question of which topics they wished had received more attention during the seminar. No topic received a majority of responses. The top two items identified were drug seeking behavior and diabetes, which only received 3 and 4 responses respectively. Not a single respondent indicated that anger, anxiety, bipolar, depression, or hypertension should have received more attention.

Cognitive disorders, learning disorders, risky sexual behavior, trauma work, and techniques to integrate awareness of patient life circumstances into treatment were all identified by participants as topics that would have been useful to train them about.

Participants identified several categories of constraints on their training experience. They felt there were problems around insufficient time; limited access and challenges with doctors and clinic workers; clinic realities such as rules, limited space, and too many people in training; bigger picture realities such as inadequate community networks and being tasked with too many problems at once.

4. Please indicate the topics and protocols presented during the Behavioral Health Seminar that were MOST RELEVANT to the presenting problems of your patients and your behavioral health services at the community health centers (primary care settings).

Item	Response Count	Response Percent
emotional dysregulation	8	100.0%
anxiety	8	100.0%
stress	7	87.5%
depression	7	87.5%
PTSD	6	75.0%
chronic pain	6	75.0%
substance abuse	5	62.5%
diabetes	5	62.5%
sleep disorders	4	50.0%
crisis	4	50.0%
anger	4	50.0%
suicidality	3	37.5%
bipolar	3	37.5%
medical non-comp	2	25.0%
isolation	2	25.0%
interpersonal prob	2	25.0%
drug seeking behavior	2	25.0%
thought disorder	1	12.5%
hypertension	1	12.5%
grief	1	12.5%
eating and nutritional	1	12.5%
smoking cessation	0	0.0%

5. Please indicate any topics or presenting problems that needed MORE ATTENTION DURING THE SEMINAR to prepare you for working at the community health center (primary care setting). Check all that apply		
Item	Response Count	Response Percent
drug seeking behavior	4	57.1%
diabetes	3	42.9%
crisis	2	28.6%
eating and nutritional	2	28.6%
emotional dysregulation	2	28.6%
chronic pain	1	14.3%
grief	1	14.3%
interpersonal prob	1	14.3%
isolation	1	14.3%
medical non-comp	1	14.3%
sleep disorders	1	14.3%
substance abuse	1	14.3%
PTSD	1	14.3%
suicidality	1	14.3%
smoking cessation	1	14.3%
thought disorder	1	14.3%
anger	0	0.0%
anxiety	0	0.0%
bipolar	0	0.0%
depression	0	0.0%
hypertension	0	0.0%

6. Were there any other issues or treatments you felt less prepared to address?

Participants responded to this question by writing in these comments.

- Cognitive disorders, learning disorders.
- Risky sexual behavior.
- I did not feel prepared to do trauma work (EMDR, or any other protocol we addressed) with the population I worked with. For the most part they were living in extremely unstable environments and could not handle the added stress of the work. More attention should be paid to patient life circumstances, as those are often huge impediments to treatment.

7. Please rate the extent to which you were PREPARED TO USE (understood how and when to use) each of the following client inventories and assessments.

Item	Not at all prepared	Inadeq'ly prepared	Adequ'ly prepared	Strongly prepared	Clinic did not permit use	Mean
Session Feedback	0	0	3	4	1	3.57
Beck Anxiety Inventory (BAI)	0	0	5	3	0	3.38
DASS	0	1	2	3	2	3.33
The Michigan Alcohol Screening Test (MAST)	0	1	2	3	2	3.33
The Drug Abuse Screening Test (DAST)	0	1	2	3	2	3.33
Suicidality Assessment or FASI	0	1	3	3	1	3.29
Trauma Screening Questionnaire(TSQ)	0	1	4	3	0	3.25
Beck Depression Inventory (BDI-II)	0	1	4	3	0	3.25
Difficulties in Emotion Regulation (DERS)	1	0	4	2	1	3
Holmes and Rahe Stress Scale	1	1	1	3	2	3

- The clinic had its own assessment tools with others in development in order to be most sensitive to the diversity of the population it served.
- Many of the forms were simple paper and pen things to fill out, but we were not taught how to use the results to guide treatment. We were only taught to use them as progress monitors.

8. What were the Top 3 barriers you encountered in conducting primary care consultations?

Participants experience a range of barriers to consultation. Their comments about barriers are categorized below.

Time

- Time (limited).
- Limitations of time.
- Time restraints.

Doctors & Clinic Workers

- Not enough consults from doctors.
- Doctor buy-in / utilization.
- Consultations were primarily with a few select MDs.
- The providers at my clinic do so much already, SSI, housing, etc. for their patients that it took a lot of time to earn trust.
- M.D.s didn't know very well (despite Temre's wonderful presentations) how we could be useful... I had to remind them regularly, for example, that I could help with diet, sleep hygiene, etc.
- Personalities of primary care providers.

Clinic Realities

- Clinic rules.
- Uninterrupted space.
- Space.
- Number of other trainees (nurse, interns, americore etc) at site overwhelmed staff.
- Separation between behavioral health and primary care w/in clinic.

Bigger Picture Barriers

- Inadequate breadth of community referral agencies/knowledge of social work networking.
- Having too wide a scope of problems I could deal with (start with a small list, stress reduction, depression, schizophrenia, whatever) and build a reputation and move from there.

Area of Questioning: GROUP FACILITATION

Six participants facilitated a group as part of their training. Of the six, only two felt they were well supported and trained to facilitate a group (average rating of 2.67). Comments indicate that efforts at training were well intentioned, but missed the mark a bit either due to a mismatch of a trainer with the specifics of their on-site groups.

9. If you facilitated a group, please indicate the extent to which the training and supervision you received supported your ability to facilitate a group.				
Not at all	A little	Somewhat	To a great extent	Mean
1	2	1	2	2.67

Respondent had two comments to share about the supervision the received related to group facilitation.

- Some of the supervisor's guidance was helpful; however, it was challenging having a psychodynamic supervisor teaching skills based groups in a hospital setting. There was a lack of consistency in theoretical explanation/formulation that may have caused some confusion at times.
- Supervision was supportive with offers of help, but most structure came from within site and staff there. No complaints! Worked just fine

Area of Questioning: BENEFITS OF IHPTP

Participants indicated they developed their ability through the program most in relation to “work in a multi-disciplinary setting” and “prioritize treatment interventions based on prioritizing multiple problems (both 3.63) and least in relation to “work with ethnically diverse populations” (2.88).

The items addressing professional competencies outside of interacting with patients (understanding of systems, interacting with medical providers) were largely adequately or strongly supported as a result of participation in IHPTP, with responses to all items averaging out to above adequate.

10. My IHPTP experiences contributed to my ability to:					
Item	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
a. Work in a multi-disciplinary setting (physicians, nurses, social workers, physical therapists, etc.).	0	0	3	5	3.63
g. Prioritize treatments interventions based on prioritizing multiple problems.	0	1	1	6	3.63
c. Identify problems quickly.	0	0	4	4	3.5
o. Work collaboratively with providers from other disciplines.	0	0	4	4	3.5
b. Administer brief assessments.	0	0	5	3	3.38
e. Rapidly identify problems through behavioral health consults "clinical encounters".	0	1	3	4	3.38
j. Read medical charts.	0	0	5	3	3.38
k. Write clear concise medical chart notes.	0	0	5	3	3.38
l. Integrate feedback from supervisors.	0	0	5	3	3.38
d. Make a differential diagnosis.	0	0	6	2	3.25
f. Apply the appropriate intervention to an identified problem.	0	1	4	3	3.25
h. Provide time limited interventions that focus on behavioral aspects of patients presenting problems.	0	1	4	3	3.25
i. Seek out appropriate resources and referral.	0	1	4	3	3.25
m. Work effectively with traumatized, low income, complex populations.	1	0	3	4	3.25
n. Work effectively with ethnically diverse populations.	1	1	4	2	2.88

11. My participation in IHPTP contributed to my:					
Item	Not Present, Not Needed	Inadequate Trn'g or Support	Adequate Trn'g or Support	Strong Trn'g or Support	Mean
a. Understanding of the relationship of medical and psychological systems (mind/body connection) biopsychosocial model of treatment.	0	0	4	4	3.5
e. Effectiveness consulting with medical providers.	0	0	4	4	3.5
f. Comfort consulting with medical providers.	0	0	4	4	3.5
b. Ability to ask relative questions to provide a more comprehensive picture of a problem.	0	0	5	3	3.38
d. Understanding of issues related to access to care.	1	0	4	3	3.13

Area of Questioning: FUTURE PLANS

Almost all IHPTP participants responding to the survey are all much more likely to be involved in an integrated health setting as a result of their experience. Only one person indicated they were only somewhat more likely and no one indicated they are much or somewhat less likely. Comments indicate that the on-site aspect of the program had the most impact.

12. Are you more or less likely to be involved in an integrated health setting (e.g., health psychology, primary care, physical, medical, rehab psych, etc.) as a result of your experiences in IHPTP?				
Much less likely	Somewhat less likely	Somewhat more likely	Much more likely	Mean
0	0	1	7	3.88

Respondents commented about how the clinical experience made them more interested in pursuing this area of psychology as well as ways they felt the theoretical training could have been improved.

Increased Professional Interest

- It was very quickly apparent how much greater of a difference I could make in an integrated health setting than I could in "private clinic" settings. It was very fulfilling to see how our work didn't just

help people cope with depression or anxiety, but in addition, could help prolong life and quality. I also felt that my profession was much better 'justified' in the medical setting... instead of a luxury, my services were a crucial part of the patient's recovery. I know I can look forward to continuing in this direction.

1.

- My experience at my specific site, however, was wonderful, informative, and very much a collaborative, and culturally responsive environment in which to work and learn.

2.

- Learned that health psychology is an interest I will likely pursue professionally

Suggestions for Training Improvements

- My experience with IHPTP training was somewhat disappointing. There was inadequate attention paid to access to care, and the complexity of the populations that use community clinics, which made the interventions we were taught difficult to implement.

3.

- More emphasis on a bio/psycho/social model would have been helpful.

Area of Questioning: SUGGESTIONS FOR IMPROVEMENT & OTHER BENEFITS OF EXPERIENCE

13. Based on your experiences during IHPTP, what suggestions do you have to improve the practicum for future students?

Participants offered a range of suggestions for improving the program. Ideas for content covered specific methodologies and cultural factors. Participants saw opportunities for on-site support that could come through supervisors or peers, and offered ideas for collaboration of the Wright institute with their individual sites that would increase training effectiveness overall.

Training Content

- Instead of simply developing a sympathy for patients of ethnic minorities, it would have been important to discuss how culture should affect intervention decisions, and how interventions can be adapted to better conform to a patient's culture.
- More emphasis on a bio/psycho/social model, frequent role plays between students, video/audio recordings that everyone shares with one another.

On-site Support

- One suggestion is to have the Wright supervisors spend more time at our placement. This way, supervisors at the clinic better understand the students' role.
- More team building within the group, as we're at different sites, but have the potential to be of great support to one another.

4.

More Training-Related Collaboration with Clinics

- Greater sensitivity to the particular mission of individual agencies that tailor their philosophy and treatment approach to the particular needs of their population for whom our general training IHPTP approach may need to be adapted. While behavioral health obviously calls for an understanding of CBT tx approaches, it could also include more integrative formulation training - thus, it might be interesting to have occasional supplementary lectures from psychodynamic approaches about similarly brief treatment protocols to best explore the breadth and depth of this increasingly important direction (i.e. behavioral health) for psychologists.
- An improved collaborative relationship with the clinic sites for a more even, standard training.

14. In what ways did your IHPTP experiences benefit you most?

Participants express increased in the areas of technical skills, practical experience & exposure, and their confidence & flexibility. Particularly notable were their new ability to manage brief assessments and treatments and to work with diverse groups of care givers and patients.

Technical Skills

- I learned behavioral health interventions and how to work with complex problems in health setting.
- Brief assessment strategies and the brilliance of motivational interviewing for these settings.
- Also, learned a variety of brief treatments that will assist in patient care regardless of the setting.

Practical Experience & Exposure

- Opportunity to work as part of an integrated team.
- Exposure to a diverse range of patients, both culturally and in terms of clinical presentation.
- I also gained a great deal of experience working with doctors, nurses, and social workers.
- I developed a love for community health and learned the importance of integrated care.

Confidence & Flexibility

- The training improved my flexibility as a clinician and as a member of an inter-disciplinary team
- Confidence as a clinician!
- Working as part of a multidisciplinary team.

Area of Questioning: ADDITIONAL COMMENTS

15. Additional Comments?

- Patricia (our individual supervisor) was wonderful. She was very supportive and encouraged students to apply interventions that were very useful for the patient population. She cared about the patients and the students, which evident in supervision.

Appendix B
Summary of Student Weekly Logs

BRIEF OVERVIEW OF IHPTP STUDENT WEEKLY LOGS TO DATE
2009-2010 Academic Year

- Total of 209 logs available for 8 Students
- Between 9 and 40 logs available per student

Table 1. Frequency of Consultations by Students

Frequency of Consults to Date	Medical Consults (N = 8)	Individual Consults (N = 8)	Group Consults (N = 6)
Total Number of Consults	240	738	52
Average # Per Student	24	64	7
Average # Per Student Per Week	1	4	1
Average Length of Consults	30 minutes	58 minutes	120 minutes
Min/Max Length of Consults (minutes)	min=3 max=180	Min=10 man=180	min=60 max=270

Most Frequent Reasons for Medical Consults:

- Depression
- Anxiety
- Stress
- Substance Abuse
- PTSD

Problem Most Frequently Addressed in Individual Consults:

- Depression

Problems Often Addressed in Individual Consults:

- Anxiety
- Stress
- Interpersonal problems

Problems Sometimes Addressed in Individual Consults:

- PTSD
- Substance Abuse
- Isolation
- Thought disorder
- Diabetes
- Chronic pain
- Anger
- Bipolar

Problems Rarely Addressed in Individual Consults:

- Medical non-comp
- Eating and nutritional
- Hypertension
- Sleep disorders

- Drug seeking behavior
- Grief
- Smoking cessation

Group Sessions

- Better Quality of Life
- Sobriety Circle
- Smoking Cessation
- Coping with the Holidays
- Mindfulness-Based Stress Reduction
- Self-Esteem