The Behavioral Health Integration Project

Final Report

2017-2025

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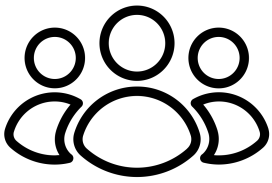
Executive Summary

The Behavioral Health Integration Project (BHIP) was a federally funded grant project that offered Portland State University master's of social work students with a dual interest in integrated behavioral health and working with rural and/or medically underserved populations the opportunity to receive specialized training in behavioral health integration.

Integrated behavioral health is more than addressing mental health or physical health concerns. It is a philosophy of care that deepens understanding of the complex interactions of organic, external, and individual factors that impact health and well-being. Students developed skills in assessing and addressing these complex interactions that could be applied in a variety of settings. BHIP cohort members received additional training and support, and a $10,000 stipend, distributed over the advanced practice year of their master's program.

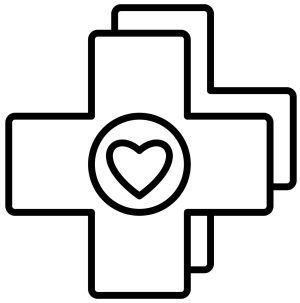
The primary goal of BHIP was workforce development in behavioral health integration with a focus on training those from and those working with rural and historically underserved communities (e.g. Black, Indigenous, People of Color, low-income, immigrants and refugees, LGBTQ+). All participants were asked to make a commitment to pursuing post-graduation employment in working with or in these communities.

BHIP ran for a total of eight academic years, from 2017 to 2025. Over the course of our eight cohorts, we supported more than 230 students, providing them with more than $2 million in stipends. Students worked up to 500 hours at each of their advanced practicum placements, with hours varying for students enrolled in the first year of the COVID-19 pandemic, coming to a total of more than 100,000 practicum hours. Eighty-one BHIP students identified as coming from rural backgrounds, 112 from disadvantaged backgrounds, and 99 as a non-white/non-hispanic race.



> 200 Students Supported

> $2,000,000 in Stipends



> 100,000 Practicum Hours

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Spotlight on Project Participants

Michael Waller

Michael is currently a school social worker at McDaniel High School. As a CWSA he is gaining the necessary hours of supervised clinical experience to qualify for an LCSW license. A lot of his work revolves around suicide prevention, screening, assessing and safety planning.

His experience with BHIP started in grad school, taking courses like Integrated Health Care and Brief Behavioral Interventions & Treatment. Without those courses he believes he wouldn't have gained the necessary knowledge to integrate behavioral health into schools.

While it is still a work in progress he is happy to have a team (includes a school psychologist, QMHP's and school social workers) that collaborates with the Multnomah student health center (behavioral health therapist, nurse and physician). Using a team-based approach has made it easier in identifying the behavioral factors like mental health issues, academic concerns, emotional concerns and substance use. Their behavioral health model that consists of CBT, Mindfulness, Narrative and Solution-focused has helped treat and support students much more effectively.

Alex Rice

After graduating, Alex continued working as a full-time counselor at Volunteers of America Men's Residential Center. She began working with more clients experiencing SPMI. In doing so she has gained more experience working with mental health medication prescribers and naturopathic doctors. She has continued to educate herself on the impacts of medications and work with providers and clients in finding the best treatment plan. Being a community-based substance abuse center, Volunteers of America has worked to integrate more providers into the treatment at their center. They offer naturopathic services, acupuncture, chiropractic care, medically assisted treatment prescribers, and mental health medication providers. In addiction treatment, they have noticed for many years a connection between sex and relapse on substances. Due to this Alex and a coworker have begun teaching a new curriculum called Sexual Health and Recovery, where they utilize a written curriculum, speak with other team members, and curate it to their population.

Francesca Caponi

Francesca is currently working as an Oncosexologist, specializing in the field of sex therapy and oncology in an outpatient setting. She is an LCSW, OSW-C certified and working toward AASECT certification. She sees patients for a range of sexual dysfunctions including low libido, pain during intercourse, ED, etc. and following cancer treatment, (chemotherapy, radiation, surgery). She frequently provides webinars for fellow providers, Physician Assistants, and Radiation therapists, and recently provided CEUs to the Association of Oncology Social Workers in this topic.

In Memoriam

Derrick Thomas

Derrick Thomas, a member of the first BHIP cohort, passed away in 2022.

Derrick was a caring, genuine, and committed person who was welcoming and inclusive of everyone. He dedicated most of his adult life to advocating for social justice in underserved communities, including vulnerable youth, individuals who experience mental health challenges, survivors of traumatic brain injuries, and individuals who experience cognitive and developmental delays. His dominant driving force was the belief that those with knowledge have a social obligation to provide knowledge to those without, and those with the capacity to care are equally obligated to provide care to those who lack the capacity to care for themselves. He was an avid runner, a veteran, and a Brazilian Jiu-Jitsu competitor. To know Derrick was to know his huge smile, passion, and the undeniable sparkle in his eyes.

Acknowledgements

The success of the Behavioral Health Integration Project would not have been possible without the intellectual labor and contributions of Dr. Pauline Jivanjee, Michelle Martinez-Thompason, Dr. Laura Nissen, Lisa Hawash, Cimone Campbell, Eddie May, Monica Parmley-Frutiger, Dr. Keva Miller, Julie Kates, Michelle Morales, Val Hamby, Gary Smith, Denise Grant, Lisa Cordova, Adrienne Graf, Marina Barcelo, Jessica Hayes, Leah Allen, Becca Love, Bethany Wallace, Dr. Mary Oschwald, Jennifer Williams, Natasha Stockem, Holly Hein, DJ Marty, Kerry Taylor, Kit Monae, Sarah Porter, and the many practicum supervisors who supported BHIP students.

The Behavioral Health Integration Project

The Behavioral Health Integration Project (BHIP) was a $3.8 million federally funded workforce development project to address behavioral health needs across Oregon, with an emphasis on rural and underserved regions. BHIP provided $10,000 stipends, specialized courses, field placements, and advising to MSW students in their advanced year of study.

The PSU School of Social Work is one of the major sources of workforce development for the CCOs and their contract agencies. We are the major source of both health and behavioral health field experiences for MSW students and graduates. PSU recognizes that social work professionals need the training and skills to support models that effectively integrate behavioral health in primary care settings and models that effectively integrate physical health in behavioral health settings. In both instances, the emphasis should be on supporting best-practices for screening and providing brief, solution-focused treatment to people with co-occurring disorders, emergent serious mental health conditions, or those with economic, cultural and/or linguistic barriers to health care, and limited access to services.

Medically underserved populations include LGBTQ2S+ and those with economic, cultural, or linguistic barriers to health care and/or who have limited access to primary care services. Oregon’s medically underserved populations are located in both rural and urban areas.

Social determinants of health play a significant role in the health and well-being of children and youth and those in medically underserved populations. Health behaviors such as smoking, obesity, and chronic stress are associated with many chronic and life-threatening illnesses. Early health screening, assessment, and intervention can help reduce negative outcomes. In Oregon, social determinants of health play a significant role in negative health outcomes. Latina, African-American, and American Indian/Alaskan Native women are less likely to access prenatal care than non-Latina white women, resulting in higher rates of babies with low birth weight which can contribute to development problems in infancy (CDC Summary, 2013). Rates of obesity are highest among populations of color (CDC Summary, 2013). African Americans and American Indian/Alaskan Natives are more likely to smoke and have higher rates of asthma, diabetes, and hypertension (CDC Summary, 2013). Finally, African American and American Indian/Alaskan Native communities die younger than non-Latino white communities (CDC Summary, 2013).

In addition to racial and ethnic disparities, poverty is a significant social determinant of health. Approximately 12% of Oregon adults and 17% of children live in poverty with a disproportionate impact on children of color (Oregon's State Health Profile, 2018). Thirty-four percent Black, 29% Latino, 27% Native American, and 12% Asian children fell below the federal poverty threshold (Oregon Center for Public Policy, 2020). Poverty is exacerbated in rural areas, with a higher

proportion of Oregonians living in poverty in rural areas (16%) versus urban areas (14%; Oregon Center for Public Policy, 2020). Rates of chronic conditions such as asthma, obesity, diabetes, and cardiovascular disease are higher among the poor. Health related behaviors such as smoking, poor nutrition, and lack of physical activity are also more common among the poor. As a result, those with lower socioeconomic status experience higher rates of mortality and risk of chronic morbidity (Oregon's State Health Profile, 2018).

Portland has one of the largest LGBTQ2S+ populations in the nation. While there is no population-based data available for transgender or gender non-conforming populations in Oregon, data is available for lesbian, gay, and bisexual (LGB) adults. LGB adults have lower household incomes and are more likely to live in poverty and experience food insecurity than heterosexual adults (Oregon State Health Profile, 2012). They also experience more chronic illness including arthritis, asthma, diabetes, and cardiovascular disease than heterosexual adults (Oregon State Health Profile, 2012). LGB youth and adults are more likely to experience mental health issues and attempt suicide than heterosexual youth and adults (Oregon's State Health Assessment, 2018). Health related behaviors including smoking and low intake of fruits and vegetables are also more common (Oregon's State Health Assessment, 2018). Finally, LGB populations experience significant barriers to accessing health care including being less likely to have health insurance and a primary care provider (Oregon's State Health Assessment, 2018).

The Behavioral Health Integration Project built on the School's long and successful history of educating social workers to meet the behavioral health needs of Oregon's rural and/or medically underserved populations. Because of the unique transformation in Oregon's health care system and the success of our current funded project, the PSU SSW has the opportunity to expand the education and training of social work professionals along the continuum of behavioral health integration. The Behavioral Health Integration Project is organized around four goals: 1) to recruit and retain an increased number of graduate students from historically marginalized communities who wish to specialize in integrated behavioral health serving rural and/or medically underserved populations; 2) provide specialized curriculum, field placements, academic and career advising for advanced graduate students who are accepted into the Project; 3) support the expansion of field placement options that expertly educate advanced students in integrated behavioral health care settings serving rural and/or medically underserved populations; and 4) increase interprofessional training and collaboration.

Data Collection

The Project collected data according to requirements from our funding agency, the Health Resources and Services Administration (HRSA). This included demographic data, training experience, career goals, and post-graduation employment. Additionally, BHIP students completed skill scales, and recorded program information for our own evaluation and metric-tracking purposes.

Project Goals and Outcomes

The project aimed to expand the number of social work professionals trained to deliver behavioral health services across the lifespan in rural and/or medically underserved communities. Its four primary goals were to recruit and retain graduate students from historically marginalized communities, provide specialized training and advising, expand field placement options, and strengthen interprofessional collaboration through initiatives. The following provides the outcomes of the goals over the past eight years.

Goal 1. To recruit and retain an increased number of graduate students from historically marginalized communities who wish to specialize in integrated behavioral health serving rural and/or medically underserved populations.

In total, we had 708 students apply to participate in BHIP. We provided $2.3 million in stipends to 234 students pursuing their master's in social work degrees. Demographics tables at the student level are available in Appendices A-C. Broadly, more than 35% of Project students came from rural backgrounds, 48% identified as coming from disadvantaged backgrounds[1], 42% identified as non-white or non-hispanic race, and 18% were multilingual. We had 113 students participating in BHIP from campuses outside of Portland City Center.

In compliance with HRSA data collection practices, BHIP surveyed graduates six-months after graduation. As such, results reported here include cohorts 1-7. Cohort 8 graduated in spring of 2025. Detailed results from this survey are available in tabular form in Appendix C.

The majority of BHIP students reported employment post-graduation (80%), with 79% employed in an integrated care environment specifically. Fifty percent were employed in a medically underserved community, and 40% in a primary care setting. At the time of response, 96% students were actively working towards clinical social work licensure.

Goal 2. Provide specialized curriculum, field placements, and academic and career advising for advanced graduate students who are accepted into the Behavioral Health Integration Project.

In total, BHIP students worked more than 109,950 hours in their integrated health practicum placements, with most completing 500 hours and cohort 3 completing a minimum of 265 due to COVID-19. BHIP supported the development of two Project-specific courses: SW 556: Advanced Practice in Integrated Health Care and SW 570: Behavioral Interventions and Treatments. All BHIP students were required to enroll in both classes, but many other PSU SSW students enrolled as well. Across all eight program academic years, 463 students enrolled in SW 556 and 576 in SW 570.

	Cohort 1 2017-18	Cohort 2 2018-19	Cohort 3 2019-20	Cohort 4 2020-21	Cohort 5 2021-22	Cohort 6 2022-23	Cohort 7 2023-24	Cohort 8 2024-25
SW 556	78	64	64	64	50	50	47	46
SW 570	N/A	85	85	85	90	90	82	59

Participation in the BHIP occurred in the students' advanced years of the social work master's program, when no professional practicum seminar is provided by the program. To provide students with a space to come together about their practicum placements, BHIP held a recurring seminar session for all Project students, creating a place for students to familiarize themselves with the range of integrated health employment environments, bring experiences as case

[1] Based on the HRSA definition. HRSA defines students from disadvantaged background as (a) Comes from an environment that has inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions or nursing school (Environmentally Disadvantaged); and/or (b) Comes from a family with an annual income below a level based on low-income thresholds established by the U.S. Census Bureau, adjusted annually for changes in the Consumer Price Index (Economically Disadvantaged). The Health and Human Services (HHS) Department defines a ''low income family'' for various health professions and nursing programs included in Titles III, VII and VIII of the Public Health Service Act as having an annual income that does not exceed 200 percent of federal poverty guidelines.

studies to the group to process, and engaged in professional development. We held a total of 58 seminar sessions.

Students in all eight BHIP cohorts completed the Behavioral Health Consultant Core Competency (BHCCC) tool and Team Skills Scale before and after participating in the project.

The BHCCC tool is a self-report 53 item scale developed by Robinson and Reiter (2015) with ratings that range from 1 (low skill level) to 5 (high skill level). The BHCCC tool is designed to measure the skills and knowledge of a behavioral health consultant on an integrated team, and is organized into six domains of competence: clinical practice skills, practice management skills, consultation skills, documentation skills, team performance skills, and administrative skills.

The Team Skills Scale is a 17 item scale with ratings from 1 (poor) to 5 (excellent) developed by Hepburn, Tsukuda, and Fasser (1996) designed to measure interprofessional team skills. The Project used a slightly modified version that removed the emphasis on geriatric work. The Team Skills Scale was organized into four domains: team and group dynamics and functioning, interdisciplinary functioning, personal contributions, and prioritizing patient goals. Analyses were run on total scale mean scores and domain means to assess participant self-reported team skills.

Figures 1 and 2 provide visual representations of total scale mean scores for the BHCCC tool and the Team Skills Scale for cohort 1-7 pre- and post-scores. Additionally, statistical analyses were run for cohorts 1-4 (Ilea & Kimball, 2023), indicating students that participated in the project achieved statistically significant levels of improvement from pre- to post-tests with large effect sizes on the BHCCC tool skills ($n = 93$, Cohen's $d = -1.752$, $t(92) = -16.894$, $p < .001$) and the Team Skills Scale ($n = 94$, Cohen's $d = -1.558$, $t(93) = -15.101$, $p < .001$). Wilcoxon signed-rank rests confirmed improvements. Details on analysis can be found in Appendices D-G.

Figure 1

Mean pre- and post-scores for cohorts 1-7 on Behavioral Health Consultant Core Competency Tool

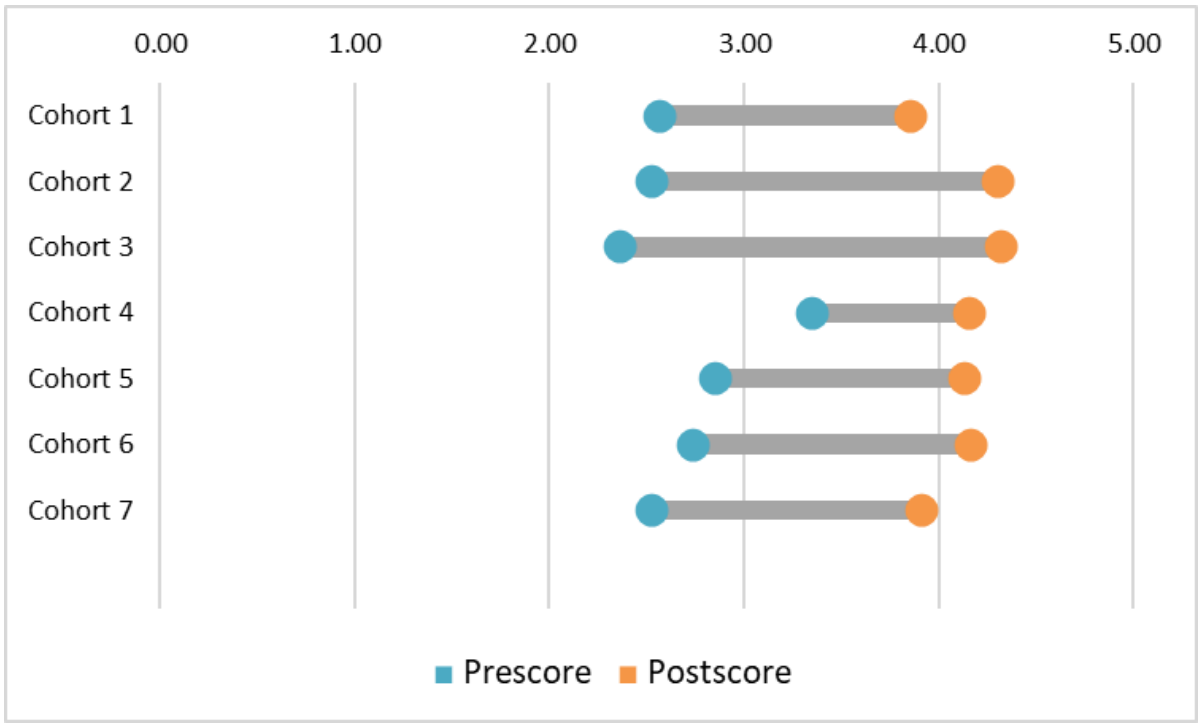
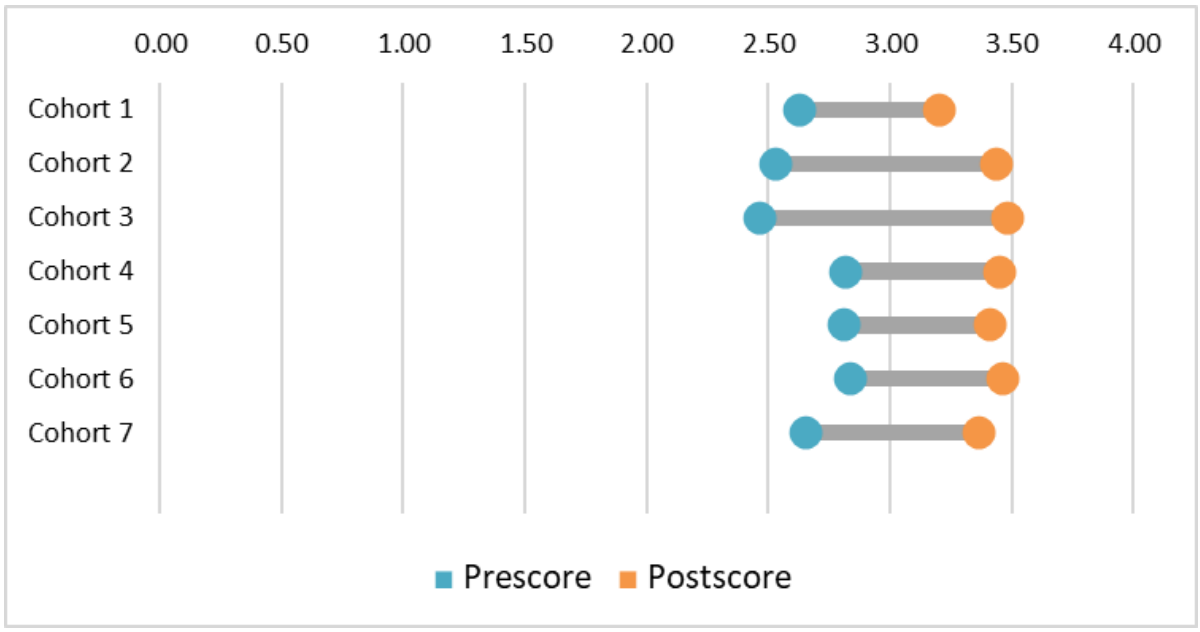


Figure 2

Mean pre- and post-scores for cohorts 1-7 on Team Skills Scale



We held a 2-day Symposium, in September 2018 and 2019 for Cohort 2 & 3. This Symposium included introduction to introduction to health models and behavioral health integration models,

Rapid Cycle Quality Improvement, trauma informed health care, transgender health care, interprofessional teamwork, and culturally relevant workshops. Students are completing SBIRT training independently through course work.

As a result of the COVID-19 pandemic, we shift the training support for students. We provided specialized training in telehealth to all BHIP students in 2020. Then we covered registration and related costs for nine students to participate in conferences or training opportunities focused on topics relevant to integrated care and the populations they were serving. These included topics such as culturally specific practices, addictions, mindfulness coaching, and post-traumatic growth. Students were extremely appreciative of these opportunities and gave feedback that they supplemented their field-based learning.

Students in cohorts 4-8 received additional specialized training in suicide assessment and intervention. We used a variety of training programs including Applied Suicide Intervention Skills Training (ASIST), YouthSave, and Care. Ask. Connect.

Goal 3. Support the increase in the number of field placement options that expertly educate advanced students in integrated behavioral health care settings serving rural and/or medically underserved populations

All of our BHIP placements have been in new or modified programs that provide services within a behavioral health integration model. Despite the COVID-19 pandemic and missing a field development position, we developed 10 new placements that served rural and/or historically marginalized populations including two tribal agencies and one large rural health system.

We sought to increase field site capacity and expert knowledge, through mini-grants to field instructors for professional development training. However, over the course of four-years, these funds have been sporadically used and did little to increase interprofessional training and collaboration.

In an attempt to fill the ongoing gap in access to affordable clinical supervision for licensure, BHIP graduates in Cohorts 4-8, were offered access to free group supervision. Roughly 60 of the 120 graduates participated or continue to participate in group supervision. Seven graduates were granted free individual supervision because they practiced in under-resourced areas or wanted more customized supervision (e.g. practice experience, cultural-specific, etc). Approximately, 3000 supervision hours have been provided free of charge to BHIP graduates pursuing their clinical license.

Goal 4. Increase interprofessional training and collaboration.

We sought to increase field site capacity and expert knowledge, through mini-grants to field instructors for professional development training. However, over the course of four-years, these funds have been sporadically used and did little to increase interprofessional training and collaboration.

To improve training and increase interprofessional training and collaboration, we developed an eConsultation Learning cohort to enhance knowledge and skills in intimate partner violence and health. We had four different cohorts with a total of 25 participants. We also created several short video modules for future use.

Impact of BHIP on Participants

BHIP graduates had a variety of ways to provide qualitative feedback and comments on the Project. Below is a selection of what project participants had to say.

Career trajectory

Across interviews and survey feedback, participants were clear that the Project had a significant impact on their career trajectories; one participant explained that BHIP "gave me a vision as to what it is that I wanted to do once I graduated."

Many graduates also reported that having the integrated care specialization BHIP provided on their resumes directly contributed to their ease of obtaining employment post-graduation. A few graduates obtained post-graduate employment as a direct result of connections forged in their integrated field placements. A few graduates also experienced what they perceived to be a quicker ascension into leadership at their organization due to their previous BHIP experience:

> *Being able to come in to the after, like, as a new hire, and be more on top of things and feel more like I have a handle on how everything needs to work together for myself has helped me move into a leadership role faster than I imagine my counterparts would. Particularly faster than I imagine I could have if I wasn't already familiar with the environment and the ways that folks are able to engage together.*

Part of the Project's influence on career trajectory came from its ability to expose students to a variety of integrated care settings.

Exposure to integrated care settings

Students in BHIP had two avenues of exposure to integrated care settings. First, all BHIP students are placed in practicum settings with integrated care teams to practice within. Second, in the quarterly BHIP seminars, students were exposed to the entire BHIP cohort, introducing a space for discussion and introduction to other student experiences.

Regarding practicums, students reported the value of the chance to work within teams they may not have had a chance to experience otherwise; "My internship was really unique and meaningful. The job I was doing I couldn't do again until I had a LCSW so the experience was invaluable." Practicums provided students with an opportunity to see the philosophy of integrated health care in practice, and in combination with the seminar sessions, gave students a broad idea of where careers in integrated behavioral health could lead. One student said "the internship, combined with having the seminar support during the internship experience, I think those combined were really helpful for learning."

In Project seminars, students were introduced to peers placed in a variety of settings, including those working with vastly different populations, such as children's medical settings. There were opportunities to discuss the different behavior of medical providers across different settings, giving students a chance to compare across their BHIP cohorts. There were also different experiences of scale across students in the Project cohort, with some students describing more bureaucratic settings within larger systems, and the associated differences with organizational policy and program development.

One graduate explained that learning about all the different opportunities for applying integrated care across settings increased their confidence in their career choices and trajectory. Another participant described the theoretical elements of the project as contributing to their

understanding that integrated health care can look different across different workplaces, but the principles underpinning it are what make it integrated care.

Concrete skills

Graduates identified a number of concrete skills the Project provided training for that were valuable to them in post-graduation work. For example, BHIP-specific curriculum was credited across many graduates as having been responsible for their introduction to the concise documentation characteristic of medical settings, as well as assessment skills.

> *People can chart the same interaction and a whole lot of different ways, and like what is the most clear and concise and patient-centered and strength-based way to do that in a way that captures what happened. And your coworkers are going to understand and they're actually going to read. Like people's medical charts are huge, like if you write a whole page absolutely nobody is going to read it.*

Participants also found that exposure to medical records and terminology were “particularly helpful” to succeed in integrated care settings in their post-graduation employment. Medical record terminology and familiarity was critical for participants navigating medical systems.

Graduates found teachings on brief behavioral interventions useful in their future practice, including familiarity with scales commonly used in integrated primary care settings. Graduates were able to interpret patient charts or administer appropriate scales in different settings. Brief behavioral interventions and exposure to common primary care scales largely came in one of the courses designed for BHIP, which participants found pertinent and valuable to post-graduate work: “I don't think there was anything that wasn't of immediate practical value from that class.”

The two courses designed for BHIP students utilized a single textbook, which many graduates reported keeping and referencing on the job many times. One participant even reported encouraging a coworker in a similar position to use continuing education funding to purchase the book, considering what a valuable reference text it had proven to be.

One aspect of Project courses that participants highlighted was the curriculum related to complementary alternative medicine (CAM). Multiple graduates shared that without exposure to CAM through BHIP, they would have not had any formal education on alternative medicines. The CAM sessions provided students with learnings related to different CAM approaches that balanced breadth and concision, creating a foundation for future practice and patient experiences.

The transfer of learnings to practice

Graduates discussed multiple ways Project learnings were transferred into useful knowledge and skills in their post-graduation practice. First, participants identified particular instances where practical lessons prepared them for circumstances in their practice. Second, participants reported that the simultaneous nature of didactic learning and practicum experience during their time in the Project allowed them to learn and apply teachings concurrently, solidifying the application of those learnings. Third, participants felt that the theoretical foundation established in BHIP gave them a framework for approaching unfamiliar practice circumstances post-graduation. Finally, and most frequently, participants felt that BHIP taught them how to use a problem solving lens in their practice, seeking out other team members for collaborative questioning when they encountered a situation they felt unprepared to approach.

Graduates felt practically prepared for situations they encountered in their post-graduate practice based on certain learnings from BHIP. Role plays conducted in Project-specific courses reportedly covered topics that were commonly encountered in workplaces, leaving graduates feeling prepared and competent:

> *Actually, I had an interaction with a patient the other day that was almost identical to a roleplay I did in one of the BHIP classes, and, like immediately texted my partner that I had in the class for the roleplay the next day it was like, oh, my gosh! I was having flashbacks. This is like exactly what we learned exactly the roleplay. Things went really well for this patient and for myself, I got good feedback from the patient about the interaction, felt like I was able to, like, support and help them in a way that was really positive, and could directly correlate it to like a specific roleplay, on a specific learning, in a specific class that I took for BHIP, which was pretty cool.*

Brief intervention training such as “quick rapport building, finding out information that you need, and like, brief documentation, or like healthcare- healthcare system- hospital system-appropriate documentation” was often lauded as valuable once in the workforce, and graduates felt that without BHIP-specific curriculum they would not have had access to such learnings. Exposure to different integrated settings through BHIP seminar and cohort interactions gave participants knowledge that did not come to the surface for them personally until they were under those different circumstances in their post-graduate work.

While not all Project learnings were immediately applicable in student practicums, retrospectively, graduates said that discussion of different topics and informational learning helped set expectations for future positions and interactions with patients and family members. Safety planning, for example, was one topic graduates found valuable to have received informational learning on, whether or not it was encountered in the field pre-graduation. Being made familiar with different directions an interaction may go gave graduates confidence when they encountered those challenges in the field. Overall, graduates felt that the transition into integrated care work was eased by their experience in BHIP, because they were “already learning it prior to starting work.”

While informational learning did prove valuable for graduates, the combination of didactic and applied learnings through concurrent classes and practicum really reinforced what was being taught for some graduates:

> *It was that simultaneous learning that I was able to, that really solidified it in a way that has stayed with me. Because I was still really see the value of treating the whole person, which is the whole idea behind integrative care that you can't just treat the body. You have to treat the mind. But treating the body also means making sure that somebody has food and other securities because one cannot thrive while they're struggling to survive.*

The ability to move from learning to application quickly provided students with an opportunity to absorb teachings, building memory and confidence for application of teachings into the field. One student described being able to “go from class that weekend to my placement on Monday, or my regular job, and implement what I learned.”

When it came to the inevitability of encountering circumstances in the field that were not explicitly covered in the Project, students felt that having the theoretical foundation that the Project provided allowed them to determine how to move forward in unfamiliar encounters.

> *I think it's really important for establishing that foundation. Which I'm sure, then, in all of the subconscious and subtle ways, continues to play through the day-to-day. But I, again, like, it's something that once it's established, you don't think about it all the time, even though you can recognize when you stop and reflect that you're using it regularly. Being able to step into a role and feel like: oh, I already know how to do those different sorts of notes that are required in different settings. I know how, or knowing how to sift through them to find the information you need if it's not what's used in your area of care currently.*

And finally, the aspect of Project participation graduates identified as their most valuable learning when it came to encountering questions in their post-graduate workplaces was a problem solving lens. Graduates felt that without BHIP and its associated emphasis on interdisciplinary team work, they would not have felt confident coming into the field and asking questions of their teammates and colleagues when they encountered a challenge. They felt that BHIP "teaches you that, like you can't possibly know everything about everything in social work and things are going to happen that you don't know."

Collaboration as a central interdisciplinary team skill was underscored again and again in graduate interviews, as well as the concept of continuous learning.

> *I'd really probably just say to ask questions and to seek knowledge wherever I can get knowledge. And that can be from a variety of people. I think that's been one of my takeaways, you know. Knowledge comes from everywhere, and sometimes that's the nurse, or sometimes that's a doctor, or sometimes that's a teacher. But nobody knows everything. And ideally, we're lifelong learners. I suppose, as a mental health professional, I'm rooted in the idea that change is continuous and possible. And so I seek it out for myself, and I seek to gather from people around me. But I've just learned to be able to seek what I don't know, to be able to- and to, can you continue to try to grow the things that I think that I know. Because things are ever changing.*

These learnings came from multiple aspects of the Project, including leadership facilitation in the seminar sessions. During case consultations in seminar sessions, leadership normalized the process of reaching out for guidance when students encountered situations in their field placements where they didn't know how to move forward. This normalization increased graduate confidence and comfort in reaching out to team members or other organizational employees to learn what might be done.

Graduates came to believe that collaboration was intrinsically associated with working on an integrated care team, and a valuable tool to use when they reach a point in their work that may be unfamiliar or that they feel unprepared for.

> *The biggest thing is, you know, collaboration just in general, which is something really important to integrated care on all levels. But just thinking, like, I don't have to be the only one, the buck doesn't have to stop with me, we're a team. You know I have supervisors. I have colleagues, and medical providers that I can reach out to, and it doesn't have to just be me, you know. So I think that's one thing, if I can't find it. I definitely know people who are willing to help.*

BHIP leadership

Participants specifically identified BHIP leadership as having a valuable and lasting impact on their learning from the Project. The influence of Project leadership contributed to

participants feeling more comfortable in their roles on interdisciplinary teams, and empowered in their work.

> *So I do think that it built, it built comfort, and I don't know. I feel like, you know, Dr. Kimball, in particular, is very empowering. Like it is our role. It is our role to also be a provider, and you know our voice matters on the team. And so I've always, I've really, I felt strengthened by that and felt like, okay, i'm- People say a social worker should be here for a reason. And so I'm here to be part of this team. I might not be a medical doctor and be able to prescribe, but I am an essential part. So I really felt like that was helpful to me, and I do- I am grateful for that experience.*

Interactions with BHIP leadership occurred in a few different settings across students' advanced practice year, including Project-specific seminar sessions. Multiple participants identified seminar sessions as providing information that was missing from the rest of their program, particularly discussions around licensure and post-graduation practices. Additionally, the case consultation elements of these seminar sessions left a lasting impact for participants: "consultation was probably the most impactful for the field placement, and then, having professors that were completely available to respond in a different way than, you know, any of my other classes. Dr. Kimball specifically. She is just like: you message her, and it's instant. And even afterwards navigating my CSWA, she was helpful for that as well."

Seminar sessions provided the opportunity for BHIP leadership to normalize social work in medical and integrated settings; participants felt that conversations in seminar spaces and with leadership demystified the aspects of multidisciplinary work that they otherwise would not have necessarily received instruction on in the master's program:

> *I remember the seminar, the classes that we have with Dr. Kimball and I just liked her. I liked her energy quite a bit. And just, she kind of was a straight shooter a little bit, and kind of like, you know, gave us the low down on multidisciplinary work, and the fact that sometimes people are going to take our clinical judgment, and sometimes we're going to be the help. And people are going to treat us like that in a hospital-based setting. And so just knowing that, like, you have to have a certain temperament and know who your, who your audience is that you're talking to and tailoring towards them, framing it towards them.*

There was also a sense of leadership buy-in towards students and their success. Participants felt that the Project leadership was committed to their success, and supported them to increase their competency as integrated health care workers:

> *Ericka was fantastic, and I think I just remembered like this is somebody who's just very committed to this work. And I think even- so, that wasn't exactly what you mentioned. I don't know how you'll put in, just like the expertise and energy, and like real commitment to our, to our… "success" sounds really cheesy, but you know, our real, our competency, was palpable. And, and so that, she was a big factor, honestly. I really look for quality instruction. And I like to learn from smart people. So that was a big deal to me.*

Even after graduation, BHIP leaders modeled maintaining a network of integrated workers connected through mutual aid, and inspired a similar orientation to networking for graduates: "Oh, accessing research. [Dr. Kimball] also offered to like be available for us for research articles and things beyond school." Participants saw the value in such practices, and felt they

could “continue to try and stay connected to different people, and also offer back to them in the same way if I can.”

Confidence

The most commonly reported byproduct of Project participation by interviewees was an increased confidence in integrated care settings. Participants found strength within the process of identity formation that BHIP facilitated. Participants went into their first job out of undergrad with more confidence than would have otherwise had because of BHIP.

> I think that BHIP definitely enhanced my final year in the program. Like, allowed me to go a lot deeper and build a lot of confidence in the skills. [...]I didn't have a course that always necessarily felt as relevant to me in my practicum as my BHIP work did.

Participants reported this increased confidence across the board, from an increased assurance in interactions with other professions on integrated teams to their presentation and conduct in interviews. One participant claimed that BHIP provided them with the “skills that made me confident to apply for the jobs right out of school that I was nervous about.” The Project reportedly demystified the medical hierarchy for participants and correspondingly increased confidence operating within the hierarchy as a social work team member.

> Yeah. And I think also, I had also learned in the program just kind of some of the hierarchy in the medical industry. [...] For example, I know if I need some kind of records, I'm going to go to the MA or to the reception desk, for example, before I'm going to go to the medical provider and take their time with something like that.

The language of integrated care

Many participants reported the most valuable component of BHIP participation were learnings around the language of integrated behavioral health. Participants emphasized the importance of learning not only specialized language, but also the ability to communicate integrated health concepts across fields and team roles. BHIP introduced students to the reality of different positions on integrated care teams having different orientations to their jobs, patients, and health. Increased comprehension of this team dynamic allowed students to communicate across roles with their ultimate goal of promoting integrated care in mind.

> *When you go into a clinic, you know, a nurse is worried about a very different thing than I am as a health care professional, and that's just the nature. While we're both dedicated to providing care, the way that we provide care and our perspective of care can really differ.*

Participants reiterated the importance of understanding the perspectives of other members of a care team deeply enough to be able to “translate” across fields and speak the different languages of medical professionals. Upon post-graduation employment, Project participants reported being “able to communicate with medical teams, I think better than my cohorts that have never had that experience, and I really do think it's a language.” This translation and communication across team members included the organization of information, and consideration of their audience.

> *The whole thing about integrated care that we might have different roles. But we're all working to accomplish this increase in wellbeing and that requires communication. [...] and that also requires the ability to speak their language to some degree. [...] Not just beating the sound of my own drum, but learning to listen to theirs, so that I can reflect*

> *what it is that my needs are, or what my concerns are in a way that they might understand.*

The learnings around the languages used by other care professionals allowed participants to provide integrated care to patients with “one less barrier to overcome.” These linguistic learnings were often the result of different lenses, which participants felt they were exposed to in BHIP. Being trained to recognize the different lenses at work within a care team allowed participants to apply this learning to teams they worked on post-graduation.

Post-BHIP group supervision

Many graduates found the post-Project group supervision offered by BHIP leadership to be an unexpectedly impactful element of participation. The connection to a community of integrated care workers provided an opportunity for graduates to continue with the cohort experience of discussion across settings and teams but with a similar philosophical orientation to patient care.

> *And actually, the thing that I think has been the most helpful is that Ericka offers group supervision to BHIP graduates [...] That's been incredible. Having that consistent group has been a real kind of cohort feel and have any opportunity to like talk to other folks who I wouldn't otherwise connect with, who are doing similar work or, or totally different work, but with a similar perspective. Having a place to like, bring my thoughts about my own agency that aren't to my agency supervisor. That's, that's been the best part.*

Graduates valued the outside perspectives that resulted from their group supervision, emphasizing the opportunity it created to reflect with their workplace culture, and how it may contrast or compare to others’. One graduate explained that "normalcy is just a matter of what you get used to, and you can get used to a lot of things if you don't take the time to reflect with it. And reflection takes outside perspective.” While many graduates took care to describe the value of the stipend BHIP provided to their graduate school experience, there was simultaneously an intense emphasis on the value of a continued connection to an integrated care community: “As a graduate student, the stipend was invaluable. The knowledge that I learned was super useful. And then the ability to have continued connection to that learning environment is probably one of the most valuable things that I have.”

One graduate identified the group supervision as being particularly timely due to the nature of the transition period to post-graduation employment. While adapting to a new environment and adjusting to their role within the setting, supervision provided an opportunity to continue to question the status quo, and consider where the shared philosophy of integrated care may not yet be fully realized within their new workplace. Supervision provided a chance to balance the overwhelm, and the desire to “tuck our tail, keep our head down, and just go with the flow” during the initial transition to the workforce. A continued connection to the Project cohort and leadership provided stability during an inherently unstable career period.

> I valued – again, the stipend was valuable – but the educational experience and the educational connection that I've been able to have to maintain has really been, it feels drastic to say life saving for me. But it really just has been professionally has been, it’s provided professional stability for me at times. And also just the ability to know like, no, it's all right to fight this one. Or it's okay to take a step back or no, these are normal growing pains. Have provided sustainability for me. That's the word I wanted. Has provided sustainability for me in a way that might not have otherwise been possible.

Recommendations for the Future

While BHIP successfully prepared graduates for careers in integrated behavioral health care, sustaining and scaling these outcomes requires broader systemic investment. First, increasing the number of workers in the workforce will not address ongoing behavioral health needs without also investing in expanded resources across the care continuum. The unmet needs have little to do with the lack of workers and more to do with the limited programs and services available across the state, particularly in underserved and rural areas. Investments and stable funding in care across the continuum for mental health and substance use programs would expand job opportunities and go a long way in meeting the pervasive and persistent behavioral health needs in Oregon.

Second, payment structures beyond fee-for-service models are essential. Value-based care and alternative payment models would better reflect the collaborative and preventive nature of integrated behavioral health, allowing providers to deliver comprehensive care without the limitations of billing tied solely to direct client contact.

Third, policy changes to make the Clinical Social Work Associate (CSWA) a billable license would both increase access to care and improve workforce sustainability. Allowing CSWAs to bill for services would help fill gaps in service delivery, reduce pressure on agencies, and enable early-career social workers to contribute more fully to their organizations while pursuing licensure.

Finally, expanding access to free or subsidized clinical supervision. High costs and limited access to supervision are significant barriers for graduates, particularly those serving in under-resourced communities. Encouraging healthcare systems, social service agencies, and professional organizations to provide supervision as a covered or supported resource would improve retention, reduce inequities in the pathway to licensure, and ensure the long-term stability of the behavioral health workforce.

Conclusion

The Behavioral Health Integration Project demonstrated significant success in preparing master's-level social work students for careers in integrated health care. Through financial support, specialized coursework, practicum hours, and ongoing supervision, BHIP provided students with the skills, confidence, and professional identity needed to enter the workforce ready to contribute meaningfully.

Data from competency assessments confirmed measurable improvements in clinical and team-based skills, while post-graduation surveys revealed high rates of employment in integrated care, particularly in underserved communities. These outcomes highlight BHIP's effectiveness not only in supporting student development but also in advancing HRSA's mission to strengthen the behavioral health workforce.

Equally important, BHIP's influence extended beyond quantitative outcomes to the lived experiences of participants. Students consistently emphasized how the program shaped their career trajectories, accelerated leadership opportunities, and fostered collaboration across disciplines. The combination of financial stipends, mentorship, and continued group supervision created both immediate and lasting benefits, equipping graduates with practical tools and a supportive professional network.

Ultimately, BHIP stands as a model for how targeted investment in education, training, and community strengthened the behavioral health workforce and ensured that graduates are

well-prepared to serve diverse populations in integrated care settings. However, the ongoing limitations of clinical supervision, billing, and care across the continuum programs will continue to limit the impact of behavioral health workforce development efforts in communities.

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Appendix A

Table 1
Project Participant Demographics, Cohorts 1 through 4

	Cohort 1		Cohort 2		Cohort 3		Cohort 4	
	n	%	*n*	%	*n*	%	*n*	%
Total students	29	100	29	100	30	100	30	100
Rural background	N/A	N/A	15	52	10	33	13	43
Disadvantaged background	N/A	N/A	26	90	12	40	10	33
Veteran	3	10	0	0	0	0	2	7
Multilingual	10	34	10	34	12	40	9	30
Campus								
Central / Salem / Eugene	0	0	4	14	7	23	3	10
Eastern / Bend	0	0	5	17	0	0	0	0
Online	0	0	7	24	10	33	7	23
Portland	21	72	13	45	13	43	16	53
Southern Oregon / Ashland	8	28	0	0	0	0	4	13
Race / ethnicity								
White or caucasian	24	83	18	62	25	83	18	60
Hispanic	1	3	5	17	4	13	5	17
Black or African-American	3	10	4	14	1	3	4	13
Mixed-Race	2	7	0	0	0	0	0	0
Mexican	0	0	2	7	0	0	0	0
Mexican-American	0	0	1	3	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	1	3	0	0	0	0
American Indian or Alaska Native	0	0	2	7	3	10	1	3
Asian	0	0	2	7	0	0	0	0
Indigenous	0	0	0	0	1	3	1	3
Latinx	0	0	1	3	1	3	0	0

Appendix B

Table 2

Project Participant Demographics, Cohorts 5 through 8

	Cohort 5		Cohort 6		Cohort 7		Cohort 8	
	n	%	*n*	%	*n*	%	*n*	%
Total students	26	100	33	100	28	100	29	100
Rural background	9	35	15	45	11	39	8	28
Disadvantaged background	10	38	21	64	17	61	16	55
Veteran	2	8	0	0	1	4	1	3
Multilingual	8	31	12	36	11	39	10	34
Campus								
Central / Salem / Eugene	5	19	2	6	3	11	2	7
Eastern / Bend	5	19	0	0	1	4	0	0
Online	1	4	10	30	13	46	12	41
Portland	15	58	17	52	11	39	15	52
Southern Oregon	0	0	4	12	0	0	0	0
Race / ethnicity								
White	19	73	18	55	21	75	18	62
Hispanic or Latinx	7	27	11	33	2	7	6	21
Black or African-American	1	4	5	15	5	18	5	17
Native Hawaiian or Other Pacific Islander	1	4	0	0	0	0	0	0
American Indian or Alaska Native	2	8	5	15	2	7	2	7
Asian	0	0	3	9	2	7	1	3
Middle Eastern	1	4	0	0	0	0	0	0

Appendix C

Table 3

Project Participant Follow Up Data, Cohorts 1 through 3 and 5 through 7

	Students	
	n	%
All graduates cohorts 1-3 and 5-6 with follow up data	146	100
Employed at post-graduation follow up		
Employed full time	99	68
Employed part time	17	12
Not employed	5	3
Employment type		
City or state	21	14
Non-profit	69	47
Federal	6	4
Other	32	22
Employed in medically underserved community	73	50
Employed in a primary care setting	58	40
Current position integrated care status		
Completely integrated	57	39
Partly integrated	58	40
Not at all integrated	6	4
Other	7	5
Current position requires MSW degree	101	69
Current position requires graduate degree	116	79
Current position is a social work position	127	87
Currently working towards clinical social work licensure	140	96
No, but planning to seek licensure	5	3

Note. Cohort 4 graduated during the COVID-19 pandemic and did not complete a follow up survey.

Appendix D

Table 4

T-test results for Behavioral Health Consultant Core Competency Tool for Cohorts 1-4

	Pre scores		Post scores		$t(92)$	p	Cohen's d
	M	SD	M	SD			
Cumulative Averages	2.66	0.85	4.15	0.48	-16.89	<.001	-1.75
Clinical Practice Skills Domain	2.64	0.84	4.14	0.48	-17.04	<.001	-1.77
Practice Management Skills Domain	2.8	0.87	4.22	0.51	-15.34	<.001	-1.59
Consultation Skills Domain	2.53	0.88	4.05	0.6	-15.64	<.001	-1.62
Documentation Skills Domain	2.61	1.09	4.17	0.71	-12.18	<.001	-1.62
Team Performance Skills Domain	2.93	1.11	4.41	0.6	-12.71	<.001	-1.32
Administrative Skills Domain	2.5	1	4.03	0.64	-15.22	<.001	-1.58

Appendix E

Table 5

Wilcoxon signed-rank test results for Behavioral Health Consultant Core Competency Tool for Cohorts 1-4

	Pre Score Median	Post Score Median	N	*z* value	*p*
Cohort 1					
Cumulative Averages	2.64	3.81	27	4.43	<.001
Clinical Practice Skills Domain	2.59	3.82	27	4.54	<.001
Practice Management Skills Domain	2.63	4.00	27	4.35	<.001
Consultation Skills Domain	2.50	3.63	27	4.35	<.001
Documentation Skills Domain	2.67	4.00	27	3.92	<.001
Team Performance Skills Domain	3.00	4.33	27	4.12	<.001
Administrative Skills Domain	2.67	4.00	27	4.26	<.001
Cohort 2					
Cumulative Averages	2.49	4.36	26	4.46	<.001
Clinical Practice Skills Domain	2.41	4.38	26	4.46	<.001
Practice Management Skills Domain	2.50	4.38	26	4.38	<.001
Consultation Skills Domain	2.38	4.13	26	4.46	<.001
Documentation Skills Domain	2.33	4.33	26	4.18	<.001
Team Performance Skills Domain	2.83	4.67	26	4.12	<.001
Administrative Skills Domain	2.67	4.00	26	4.47	<.001
Cohort 3					
Cumulative Averages	2.29	4.36	22	4.11	<.001
Clinical Practice Skills Domain	2.26	4.35	22	4.11	<.001
Practice Management Skills Domain	2.69	4.50	22	4.11	<.001
Consultation Skills Domain	2.25	4.19	22	4.11	<.001
Documentation Skills Domain	2.00	4.62	22	4.08	<.001
Team Performance Skills Domain	2.83	5.00	22	4.11	<.001

Administrative Skills Domain	2.17	4.17	22	4.09	<.001
Cohort 4					
Cumulative Averages	3.44	4.21	18	3.64	<.001
Clinical Practice Skills Domain	3.38	4.21	18	3.62	<.001
Practice Management Skills Domain	3.56	4.13	18	3.03	=.002
Consultation Skills Domain	3.44	4.13	18	3.37	<.001
Documentation Skills Domain	3.67	4.00	18	3.31	<.001
Team Performance Skills Domain	3.50	4.50	18	3.31	<.001
Administrative Skills Domain	3.33	4.00	18	3.33	<.001

Appendix F

Table 6

T-test results for Team Skills Scale for Cohorts 1-4

	Pre scores		Post scores		*t*(93)	*p*	Cohen's *d*
	M	SD	M	SD			
Cumulative Averages	2.6	0.54	3.41	0.4	-15.1	<.001	-1.56
Team/Group Dynamics and Functioning Domain	2.6	0.56	3.29	0.47	-13.75	<.001	-1.42
Interdisciplinary Functioning Domain	2.54	0.57	3.42	0.43	-13.94	<.001	-1.44
Personal Contributions Domain	2.65	0.62	3.44	0.48	-12.21	<.001	-1.26
Prioritizing Patient Goals Domain	2.73	0.65	3.64	0.42	-12.06	<.001	-1.24

Appendix G

Table 7

Wilcoxon signed-rank test results for Team Skills Scale for Cohorts 1-4

	Pre Score Median	Post Score Median	N	*z* value	*p*
Cohort 1					
Cumulative Averages	2.59	3.29	27	4.32	<.001
Team/Group Dynamics and Functioning Domain	2.40	3.20	27	3.85	<.001
Interdisciplinary Functioning Domain	2.76	3.17	27	4.10	<.001
Personal Contributions Domain	2.75	3.25	27	4.01	<.001
Prioritizing Patient Goals Domain	3.00	3.50	27	3.43	<.001
Cohort 2					
Cumulative Averages	2.53	3.53	27	4.44	<.001
Team/Group Dynamics and Functioning Domain	2.60	3.40	27	4.31	<.001
Interdisciplinary Functioning Domain	2.50	3.33	27	4.34	<.001
Personal Contributions Domain	2.75	3.50	27	4.41	<.001
Prioritizing Patient Goals Domain	2.50	4.00	27	4.12	<.001
Cohort 3					
Cumulative Averages	2.53	3.65	23	4.00	<.001
Team/Group Dynamics and Functioning Domain	2.40	3.40	23	4.01	<.001
Interdisciplinary Functioning Domain	2.33	3.67	23	3.88	<.001
Personal Contributions Domain	2.50	3.75	23	4.11	<.001
Prioritizing Patient Goals Domain	2.50	4.00	23	4.14	<.001
Cohort 4					
Cumulative Averages	2.82	3.53	19	3.73	<.001
Team/Group Dynamics and Functioning Domain	3.00	3.40	19	3.75	<.001
Interdisciplinary Functioning Domain	2.83	3.67	19	3.75	<.001
Personal Contributions Domain	2.75	3.50	19	3.12	=.002
Prioritizing Patient Goals Domain	3.00	3.50	19	3.57	<.001